

FILING ADMINISTRATIVE REGULATIONS WITH THE SECRETARY OF STATE

(Pursuant to Government Code Section 11380.1)

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AUG 18 1959

Division of Administrative Procedure

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(GOV. CODE 11380.2)

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Division of Administrative Procedure

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Copy below is hereby certified to be a true and correct copy of regulations adopted, or amended, or an order of repeal by:

STATE DEPARTMENT OF SOCIAL WELFARE

(Agency)

Dated: August 17, 1959

By: *[Signature]*

Director

(Title)

FILEDIn the office of the Secretary of State
of the State of California

AUG 18 1959

At 3:45 o'clock P.M.
FRANK M. JORDAN, Secretary of State*[Signature]*
Assistant Secretary of State

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Fiscal

F-1030 CLAIMS

F-1030

A. MEDICAL CARE PAYMENTS

1. Payments to recipients for certain medical needs and supplies which are not included within the scope of services of the Medical Care Trust Fund Program are not to be reported on the Medical Care Claim, Form MC 800. Such expenditures are to be shown on the assistance claim as any other assistance expenditures.
2. Payments to vendors (see Sec. F-1000 B) shall be reported to the SDSW monthly on Certification Form MC-800 in triplicate.

Expenditure amounts recorded on the certification shall represent amounts expended during the month designated, without regard to months during which service was rendered.

The certification will be the only claim required to be submitted to the SDSW, a payroll listing not being required.

B. ADMINISTRATIVE EXPENSE

Claimable expenditures are governed by the same rules and regulations contained in Chapter VIII of this manual and shall be included in the Administrative Expenditure claim.

All administrative expenditures for the Medical Care Trust Fund Program shall be chargeable to the ABCD program group on time records and the Administrative Expenditure worksheets.

Warrant writing costs incurred by another county agency shall be claimed as specified in Sec. F-881.

(W&IC 114, 115, 116, 1560, 2140, 3060, 3075)

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Fiscal

GENERAL PROVISIONS

F-130

F-110 DEFINITION OF TERMS

F-110

To insure uniform understanding and application of certain words and abbreviations used in this manual, the following definitions are given:

1. Applicant - The applicant is the person requesting that aid be granted and who signs the application form. He may also be the same person to whom aid is to be paid or for whom aid is granted.
2. Payee - The payee is the person to whom the aid warrant is drawn and who has the responsibility for its disbursement for the benefit of the recipient(s). In most OAS, ANB, AFSB, and ATD cases the payee is also the recipient, except OAS, ANB and AFSB for those warrants made payable to vendors covering medical costs of recipients.
3. Recipient - The recipient is the person(s) for whose benefit the aid is paid.
4. Categorical Aid - The term "categorical aid" includes the aid grant plus the medical care vendor payments for OAS, ANB, AFSB, and ANC (including county supplemental aid in ANC) as well as aid payments to the disabled. It excludes county general relief and all other county welfare payments.
5. Authorization - The term "authorization" or "authorizing action" refers to action taken by a county board of supervisors or its duly appointed agent(s) in granting, denying, suspending, restoring, increasing, or decreasing payment of categorical aid, and returning erroneous repayments.
6. Eligible and Ineligible - The term "eligible" generally refers to meeting the requirements for the receipt of aid. The term "ineligible" generally refers to the failure to meet requirements for the receipt of aid. As used in Chapter VII, these terms refer to the meeting, or the failure to meet, requirements for federal participation in aid payments.
7. Persons Count - The term "eligible persons count" refers to the number of recipients in a particular month in whose aid payment the federal government will participate. The term "ineligible persons count" refers to the number of recipients in a particular month in whose aid payment the federal government will not participate.
8. BHI - Boarding Homes and Institutions, as used in this manual, refers to children in foster homes or institutions who receive ANC.
9. VPMI - Vendor payments to Public Medical Institutions for care of OAS, ANB and ATD recipients.

(W&IC 116)

F-130 GOVERNMENTAL PARTICIPATION IN AID PAYMENTS,
ADMINISTRATION, AND SUBVENTIONS

F-130

The Federal Government and the State Government, through the SDSW, reimburse county governments for certain expenditures incurred by them in payments of categorical aid, in administration of the welfare programs, and for certain subventions.

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A. PARTICIPATION IN CATEGORICAL AID PAYMENTS

The State Government participates in all categorical aid payments made by the counties which meet certain specific requirements as set forth in Sec. F-500. The Federal Government participates in all OAS, ANB, ANC, ATD, and VPPI payments meeting the federal requirements specified in Sec. F-520. Charts of financial participation in aid payments and formulas for calculation of governmental shares therein are provided in Sec. F-560 and F-570.

B. GOVERNMENTAL PARTICIPATION IN ADMINISTRATIVE EXPENDITURES

The Federal and State Governments reimburse county governments for certain expenditures incurred by them in administration of the welfare programs as provided in Sec. F-530 and in Chapter VIII.

C. SUBVENTIONS

Adoption subvention is available to counties as provided in Sec. F-550 and in Chapter IX.

(FSSA; W&IC)

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FISCAL

ACCOUNTABILITY

F-240

F-240

CONTROLS ON AUTHORIZATIONS TO PAY OR DISCONTINUE AID

F-240

In support of Form ABCD820 (F-770,C), Reconciliation Statement, required to be submitted with each monthly aid claim, each county shall maintain in an auditable manner and conveniently accessible to state and federal auditors, the following records:

1. A register, or its equivalent, supporting the reconciliation statement and summarizing the money effect of actions taken by the board of supervisors (or agent) in granting, modifying, or discontinuing aid. Form ABCD822, Register of County Authorizations, is recommended as being applicable in most counties for this purpose.
2. In addition to the completed, signed authorization documents required to be filed in individual case records, each county shall maintain a chronological file of authorization documents grouped according to board of supervisors (or agent) action date. Such a group is hereafter referred to as a "batch." Each batch may be subdivided by type of action, that is; new cases and restorations, increases, decreases or discontinuances. The individual documents shall be filed within each batch in state number order. To each batch shall be attached a recapitulation of the money effect of the documents included in it. This may be in the form of a listing or some other type of recapitulation suitable in the individual county. It shall, however, identify the individual cases entering into the batch totals, and shall be signed by the board clerk or agent. (See Sec. F-300.) Form ABCD821, Batch Voucher, is recommended as being applicable in most counties for this purpose. The totals of each batch voucher shall be entered in the register of authorizations (or its equivalent) referred to in Item 1, above.
3. Batch vouchers shall be grouped and totalled separately for each type of claim:
 - a. OAS
 - b. OAS-VPMI
 - c. ANB
 - d. ANB-VPMI
 - e. ATD
 - f. ATD-VPMI
 - g. APSB
 - h. ANC
 - i. ANC-BHI

Note: OAS, ANB and ATD. For recipients who are in public medical institutions include only the amount authorized to be paid directly to the recipient.

OAS-VPMI, ANB-VPMI and ATD-VPMI. Only the amount authorized to be paid to the institution shall be included.

(W&IC 114, 115, 116)

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F-250	CONTROLS ON GOVERNMENTAL PARTICIPATION IN AID PAYMENTS	F-250
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Effective controls shall be maintained by each county on:

1. Certifications or statements for individuals entering or leaving hospitals or other institutions
2. 16th and 18th birthdates in ANC
3. Mismanagement cases in ANC
4. Warrants held or suspended beyond the date they would normally be delivered to the recipient
5. Guardianship cases, and
6. All other types of cases which may change from time to time in participation status, or in which participation may vary from normal, as in some retroactive payments, OAS conditional restoration, etc.
or disabled
7. Aged, blind, non-federal cases because of the character of the institution or diagnosis.

A very important element in governmental participation is the persons count in cases eligible and ineligible for federal participation. An effective control on persons count shall be maintained in each county to assure correct reporting on claims and ready verification by state and federal representatives.

(W&IC 116)

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Fiscal AID PAYMENTS F-310

F-310 RULES GOVERNING AID PAYMENTS F-310

A. METHOD AND TIME OF PAYMENT

All aid paid shall be by warrant of the county, except that in ANC mismanagement cases aid may be paid totally or partially in kind. (See Sec. F-360.)

County warrants issued in payment of aid shall be redeemable at par. The county shall at all times guarantee the cashing of warrants without discount. If it becomes necessary for the county to register its warrants, the SDSW shall be notified at once as to arrangements made:

1. With local banks for the immediate cashing of warrants at par on demand, or
2. Through the State Department of Finance under the provision of Sec. 29870 et. seq. of the Government Code.

Payments of aid shall be made monthly in advance, except certain payments in ANC mismanagement cases (See Sec. F-360), payments of ANC for children who are living in boarding homes or institutions, and vendor payments to public medical institutions for OAS, ANB and ATD recipients. Payments of ANC for children living in boarding homes or institutions shall be paid to the boarding home or institution subsequent to the furnishing of care and support. One warrant may be issued to each boarding home or institution covering all the children receiving ANC in the home to whom board and care is given during the month, or a separate warrant may be issued for each child or family group. VPMI payments to institutions shall be made after the end of the month for which care was rendered. Such payment may be made by a single warrant for all recipients in behalf of whom vendor payment is made, or by means of a county fund transfer.

Payment is effective by deposit of the warrant, properly stamped and addressed, in the U. S. mail, or by delivery to the payee by an authorized representative of the county. Enclosures with warrants are restricted to those matters relating to administration of the program under which the warrant is issued.

Advance payment means delivery of the warrant on, or as near as possible to, but not before, the first day of the month. The warrant shall be deposited in the mail in sufficient time to insure delivery on the first postal delivery day of each month. (See Government Code 29800)

If a recipient is eligible on the first day of the month, he is entitled to receive payment for the full month (except in ANC-BHI, See ANC Manual of Policies and Procedures Sec. 226.05).

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AID PAYMENTS

Fiscal

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The state, federal, and county portions of the aid shall be paid at one time by a single warrant.

B. LIMITATIONS AS TO PAYEE

1. Recipient of Payment

Payments of aid shall be made promptly and directly to the recipients except:

- a. In cases involving guardianship or conservatorship of estates.
- b. Payments after death.
- c. In ANC (payments shall be made directly to authorized payees, except in mismanagement cases).
- d. In ANC mismanagement cases. (See Fiscal Manual Sec. F-360.)
- e. In Medical Care payments to vendors (OAS, ANB, APSB, ATD, VPML, and ANC).

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AID PAYMENTS

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2. Payments Upon Death of Recipient or Payee

If an eligible recipient, including child receiving ANC, dies on or after the first day of the month, aid shall be paid for the full month even though the warrant had not been delivered before death occurred. If the county has knowledge that the recipient died on or after the first day of the month and prior to the preparation of the warrant, except in ANC, the warrant shall be made payable to one of the following:

- a. The decedent.
- b. The duly appointed and qualified executor or administrator of the recipient's estate.
- c. Whomever the California Probate Code designates as the proper party to receive monies belonging to the decedent's estate. If the decedent's estate falls within the categories outlined in Sec. 630 of the Probate Code, Summary Probate Proceedings, the warrant may be made payable to such successor when he furnishes the county auditor with an affidavit showing his right under Sec. 630 of the Probate Code to receive the money.

If a recipient (other than ANC) dies, aid may be authorized and paid after death for periods prior to the first of the month following his death and shall be payable as outlined above.

If a recipient of OAS, AB or ATD in a Public Medical Institution dies before the end of the month, that portion of the grant authorized to be paid to the institution for that month shall remain payable to the institution.

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AID PAYMENTS

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F-310 (Continued)

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A warrant which has not been endorsed may be endorsed only by one of the following:

- d. The duly appointed and qualified executor or administrator of the recipient's estate.
 - e. Whomever the California Probate Code designates as the proper party to receive monies belonging to the decedent's estate.
- (1) If the decedent's estate falls within the categories outlined in Sec. 630 of the Probate Code, Summary Probate Proceedings, the warrant may be endorsed by such successor when he furnishes the county with an affidavit showing his right under Sec. 630 of the Probate Code to receive the money.
 - (2) Endorsements on warrants made under Summary Probate Proceedings should incorporate or refer to the affidavit required of persons claiming estates under Sec. 630 of the Probate Code, Summary Probate Proceedings. If the payee is other than the recipient, the warrant shall not become part of the payee's estate in case of the payee's death. The warrant issued to the deceased payee shall be canceled and a duplicate warrant shall be issued to the new payee.

In ANC, if the payee dies, the warrant issued to the deceased payee shall be canceled and a duplicate warrant shall be issued to the new payee.

3. Payments to Recipients Becoming Ineligible in Public Medical Institutions

When a recipient in an institution in behalf of whom a portion of his monthly grant is authorized to be paid to the institution becomes ineligible during the month through moving to non-medical ward, diagnosis of T.B. or psychosis, etc., the portion of the grant for that month authorized to be paid to the institution shall remain payable to the institution.

(W&IC 1552.3, 1560, 2140, 2183, 3075, 3460)

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Fiscal

GOVERNMENTAL PARTICIPATION

F-500

F-500 STATE PARTICIPATION IN AID PAYMENTS

F-500

The State Government participates within the statutory maxima, in all OAS, ANB, APSB, ANC, and ^{ATD} payments which are properly authorized by county boards of supervisors or their duly appointed agents and are paid to or on behalf of eligible persons provided:

1. The recipient is in receipt of one categorical aid only.
2. Payment is made for a month in which the recipient is living, and only to the recipient or the authorized payee, except in certain situations involving payment for the month in which the recipient dies. (See Sec. F-310)
3. The warrant for the payment is presented for redemption to the county treasurer within six months of its date, (Exception: two years for ANC-BHI), or if a reissued warrant, within the same time limit applying to the original warrant. (See Sec. F-320)
4. The warrant is properly endorsed. (See Sec. F-310)
5. Payment is not in kind, controlled, or restricted. Exceptions:
 - a. Payments for ANC Mismanagement Cases (see Fiscal Manual Sec. F-360 and ANC Manual Chapter 22 Aid Payments)
 - b. Vendor payments to public medical institutions (see OAS, ANB and ATD Manual Chapter 22 Aid Payments).
6. New, restored or retroactive payments or payments following suspension are made only in accordance with Chapter 22 (Aid Payments) of the OAS, AB ANC and ^{ATD} Manuals of Policies and Procedures.
7. The warrant for an initial payment is delivered during the month in which county action authorizing aid is taken, or not later in the following month than such delivery would normally be made under the county's customary fiscal procedure.

(W&IC 1510, 1511, 1553, 1554, 2020, 2021, 2186, 2187, 3025, 3042, 3084, 3087, 3087.1, 3420, 3432)

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AID CLAIMS

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F-700

TYPES OF AID CLAIMS

F-700

Governmental participation in aid payments made by the counties in the categorical aid programs is allowed by the state on the basis of claims filed by each county. Claims are filed monthly with the SDSW and are classified according to type as follows:

A. VOUCHER CLAIMS

Voucher claims, upon approval by the SDSW, are applied as credits against the monthly advances made to the counties on the basis of quarterly estimates and include the following:

1. Old Age Security
2. Aid to Needy Blind
3. Aid to Partially Self-supporting Blind Residents
4. Aid to Needy Children (excluding children in boarding homes and institutions)
5. Aid to Disabled
6. Medical Care for OAS, ANB, APSB, ANC, ANC-BHI and ATD Recipients.
7. Payments to Public Medical Institutions for OAS Recipients.
8. Payments to Public Medical Institutions for ANB Recipients.
9. Payments to Public Medical Institutions for ATD Recipients.

B. CASH CLAIMS

Cash claims for ANC in Boarding Homes and Institutions, upon approval by the SDSW, are certified to the State Controller for payment to the county by state warrant. These claims include all payments for children who are placed in boarding homes or institutions.

(W&IC 116, 1556, 1556.5, 2189, 3087.3, 3482; FSSA)

F-710

FORMS USED IN AID CLAIMS

F-710

Monthly claims for categorical aid payments are prepared on the following forms: (For Medical Care claims see Chapter 10 of this manual.)

A. CERTIFICATION, FORMS AG, BL, CA AND DA 800, ABD 800-V AND CA 800-BHI

These forms are required in triplicate and provide the certification of county officials upon which claims are approved for payment or credited against advances. They shall be signed by the county welfare director and the county auditor or auditor-controller.

B. CLAIM SUMMARY SHEET, FORMS ABD AND CA 802 AND ABD 802-V

These forms are required in triplicate, and summarize claims for individual items detailed on the aid payrolls, contra rolls, and schedules of adjustment for the current formula periods. The totals are transferred to the certification form.

Line 8 of Form ABD 802 provides for the computing and reporting of the amount of OAS and ANB assistance funds transferred to the Medical Care Revolving Fund as specified in Fiscal Manual Section F-1020 E.

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AID CLAIMS

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C. OAS, ANB, ANC CLAIM SUMMARY SHEET, FORMS ABD 802A, ABD 802B, AB 802C, CA 802A, CA 802-B, AND CA 802C

These forms, required in triplicate summarize claims for individual items detailed on the OAS, ANB, ATD, ANC voucher or BHI aid payrolls, contra rolls, and schedules of adjustment applying to the prior formula periods stated on the forms. The totals are transferred to the appropriate lines on the certification form.

D. RECONCILIATION STATEMENT, FORM A B C D 820 OR 820A

This form, required in triplicate, is prepared from batch voucher controls as provided in Sec. F-240.

(See Sec. F-770, C.)

E. AID PAYROLLS AND CONTRA ROLLS, FORMS ABD AND CA 801, CA 801-BHI AND ABD 801-V

These forms are required in original only or legible first copy. Those retained in the county (see Sec. F-210) shall be exact duplicates. The information provided for on the SDSW prescribed payroll and contra roll forms is the minimum information required. Any special county forms shall contain all of the information required by the state forms and shall not be used by a county prior to specific written approval of the SDSW.

F. SCHEDULE OF REPAYMENTS, FORM ABC 803

This form, required in original only, is used for reporting voluntary repayments for all periods and repayments of aid applying to federal formula periods prior to October 1, 1952, (APSB prior to October 1, 1947, and ANC-BHI prior to October 1, 1939). The totals are transferred directly to the appropriate lines of the certification form.

G. REPORT OF REPAYMENT, FORM A B C D 808

This form, required in original only, provides for computation of the distribution of individual repayments of aid according to governmental sharing formulas. Its detail supports the contra roll for repayments in the current and prior formula periods, the schedule of repayments for older formula periods, and voluntary repayments for all periods. All pertinent data for which provision is made on the form shall be provided for each individual repayment.

Counties should complete accurately and submit the report of repayment, Form A B C D 808. If, after a showing of accuracy, the county desires to retain these forms in county files rather than submit them to SDSW, it may request SDSW for permission. If SDSW grants permission, a copy of the Form A B C D 808 must be included with the other records which are filed together by month in a place convenient to state and federal auditors. Permission to retain Form A B C D 808 will be granted only to counties who have a showing of continuing accuracy.

H. SCHEDULE OF ADJUSTMENTS, FORMS ABD CA 816

These forms, required in original only, are used by the county to effect the necessary corrections in the current claim or in claims for prior months. The form is also used by the SDSW in making state adjustments of county claims for prior months.

(W&IC 116, 1556, 1556.5, 1560, 2140, 2189, 3075, 3087.3, 3460, 3482)

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F-730

AID CLAIMS

Fiscal

F-730 CLAIMING OF AID PAYMENTS

F-730

(Subsections A, B, E, F, and J only)

A. CLAIMS-GENERAL

County payments of categorical aid shall be listed in state case number order on aid payrolls, Forms ABD 801, ABD 801-V, CA 801 and CA 801-BHI. Exceptions: Non-federal (X) cases may be reported on separate pages of the payroll. BHI cases may be listed alphabetically by payee. OAS, ANB and ATD, VPMI claims may also be arranged in alphabetical order by names of institutions. If the alphabetical arrangements are used and there is more than one case with the same payee or in the same institution, they shall be listed in state case number order under the name of each payee or institution.

The payments being claimed shall be listed in separate payroll sections according to whether they are included in the continuing roll, current supplemental rolls, or rolls for payments applicable to prior months.

On all payrolls and contra rolls, the following information shall be provided in the appropriate headings and columns:

1. The name of the county filing the claim.
2. The month and the year of the claim.
3. The type of roll, i.e., payroll, cancelation contra roll, or repayment contra roll.
4. State case numbers.
5. In OAS, ANB, and ATD APSPB/payrolls and contra rolls the payee's name exactly as it appears in the signature on the application. If county mechanical equipment makes it advisable, the given initials only need be shown. If a guardian of the estate has been appointed, both the name of the guardian and the name of the recipient shall appear on the aid payroll. In OAS, ANB, and ATD, VPMI claims also include the name of the institution.

In ANC, the name of the payee shall be shown exactly as it appears on the latest authorization document. In ANC voucher claims, the names of the children need not be shown. In ANC-BHI the name and the amount of payment for each child and name of the payee shall be shown.

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F-730 (Continued)

F-730

6. In OAS, ANB, and ATD the warrant amount and the persons count. In APSB, the warrant amount.

In ANC, the persons count in each case for individuals eligible and ineligible for federal participation segregated as to needy eligible relative, eligible children and ineligible children; the warrant amount including any county supplemental aid; and the state basis amount.

In OAS, ANB and ATD, VPML, the persons count for each case on which no direct payment is made to the recipient is entered in the persons count column (3) in the "Payment to Institutions" section. If there is a direct payment to the recipient, the persons count is posted in the column (5) in the "Payment to Recipients" section, and no count is shown in Col. 3. The amount paid to the institution for each recipient, the amount paid to each recipient, and the total payment to both. If the payroll is arranged alphabetically by the names of institutions the total amount paid to each institution shall be shown in the remarks column opposite the name of the institution. If the payroll is arranged in state case number order the total amount paid to each institution shall be shown at the end of the payroll.

In ANC-BHI, the number of children, the warrant amount including any county supplemental aid, and the state basis amount. For periods prior to October 1, 1957, the state basis amount shall be segregated into columns according to county residence. In ANC-BHI, the amounts paid and basis amounts shall not be shown in total for each case but shall be segregated individually for each child in the case.

7. The warrant numbers and dates. If all warrant numbers on a given roll or page carry the same date, the date may be indicated at the beginning of the roll or top of the page rather than individually for each warrant.

In OAS, ANB and ATD, VPML claims, journal entry identifications may be used instead of warrant numbers for payments to the institutions.

8. All pages in a payroll or contra roll section shall be numbered consecutively and shall carry individual totals by page for each column. In addition to the column totals, the numbers of persons by participation status shall be totaled at the foot of each page. Page totals shall be added and footed on the last page of each section.

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F-730 (Continued)

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9. On zero grant listings show name, state number, total aid paid and status (i.e., Regular or Non-Federal). For claiming purposes zero grants are for those cases for which the grant was reduced to zero to adjust for overpayments for prior months within the current adjustment period (see F-1020 C).
10. Incapacitated parents list for ANC family cases will show state number and name of the incapacitated parent. The list will not include incapacitated parents included in the payroll as needy relatives since this would duplicate the persons count (see F-1020 C).
11. In order to be reimbursed for the state share of the transfer to the MC Revolving Fund of OAS, ANB and APSB assistance funds, these transfers must be included as expenditures against the assistance funds. This will be accomplished by posting to Line 8, Columns A, D and J the amount of the transfer. The amount to be transferred will be determined by multiplying the number of recipients shown on the claim for the previous month (Column D, Line 5 plus Line 6) times the average special need factor.

This average special need factor will be redetermined semi-annually. At the semi-annual redetermination counties will adjust for any differences in persons counts caused by SDSW office audit of the claims.

On the Medical Care Certification, Form MC 800, the amount of transfer is also posted to Line 7. If, after the first month, the total medical care is less than the amount transferred for any program, the unexpended amount of the assistance fund transfer shown on Line 8 must be added to the amount transferred the next month and the total will be shown on Line 7 of the Medical Care Claim Certification, Form MC 800.

B. CLAIMS FOR PRIOR MONTHS

Payments for prior months may be grouped on the payroll in either of two ways:

1. According to month in state number order under each month (alphabetically by payee under each month in BHI optional).
2. In state number order only (alphabetically by payee in BHI optional) with the month to which each payment applies shown in the remarks column.

The method selected by each county shall be used consistently on each monthly claim and from month to month.

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If one warrant is issued covering more than one prior month for a given case, the total warrant amount need not be shown, but the amount paid for each individual month shall be reported separately.

Payrolls shall be grouped and totaled separately for months within the current and prior formula periods, as follows:

ANC Voucher	Current period beginning 10/1/58
ANC-BHI	Current period beginning 10/1/57
OAS, ANB and ATD	Current period beginning 10/1/59
OAS, ANB and ATD-VPMI	Current period beginning 10/1/59
ANC Voucher	Prior period 10/1/57 thru 9/30/58
	Prior period 10/1/56 thru 9/30/57
	Prior period 10/1/52 thru 9/30/56
ANC-BHI	Prior period 10/1/39 thru 9/30/57
OAS, ANB and ATD	Prior period 10/1/58 thru 9/30/59
	Prior period 10/1/56 thru 9/30/58
OAS and ANB	Prior period 10/1/52 thru 9/30/56

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E. PAYMENTS FOR PARTIAL MONTHS

1. Computation of Total Amount

In computation of a grant for a partial month, the rate of aid per day is computed on the basis of the actual number of days in the particular month involved including the beginning day of aid and the day of discontinuance.

Example A - OAS in the amount of \$75 a month begins on November 4. Aid for 27 days is paid ($27/30 \times \$75$), making a total payment of \$67.50.

Example B - ANC-BHI in the amount of \$60 a month is paid through February 24 during a 29 day month. Aid for 24 days ($24/29 \times \$60$), results in a total payment of \$49.66.

See Fiscal Manual Section F-565 for reciprocal table for computing partial month's payments.

2. Basis for State Participation

If a partial month's claim is made, the basis for state participation is the actual amount of aid paid or the maximum for a full month whichever is smaller. The state participation maximum is not prorated.

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3. Computation of ANC Payments and Basis for State Participation in Transfers
Between the Home of a Relative and a Boarding Home or Institution.

If a child is moved from the home of a relative to a boarding home or institution (or vice versa) during a month, ANC shall be computed and claimed as follows:

- a. If an amount equaling or exceeding the maximum state basis is paid in advance to the relative for the full month, or if an amount paid in advance or during the month to the relative for a partial month equals or exceeds the maximum allowable for a full month, a full month's aid is allowed on the voucher claim. No state basis is claimed on the BHI cash claim for that month.

Example A - Maximum for full month paid in advance to relative. A child is living with his mother and the monthly ANC payment of \$145 is paid to the mother on January 1. On January 25, the child is placed in a boarding home. The state basis is claimed only on a voucher claim in the maximum amount of \$145.

Example B - Maximum for partial month paid in advance to relative. A child living with his mother and receiving aid at the rate of \$165 a month is to be placed in a boarding home on January 29. The change is known in advance and on January 1 the mother is paid for 28 days in the amount of \$149.03 ($28/31 \times \165). The state basis is claimed only on the voucher claim in the maximum amount of \$145.

Example C - Transfer from BHI to relative during month. Relative paid maximum for partial month. A child living in a boarding home is moved on January 4 to his mother's home, where aid is granted in the amount of \$165 a month from January 4. The mother is paid for 28 days in the amount of \$149.03 ($28/31 \times \165). The state basis is claimed on the voucher claim only in the maximum amount of \$145.

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- b. If less than the maximum state basis is paid in advance to the relative for the full month, or if less than the maximum is paid in advance or during the month for a partial month and a payment is also made to a boarding home, the claiming of the maximum reimbursement of state funds is divided between the voucher and BHI claims. The voucher claim should show the total amount paid to the relative

and state participation for the full month, not to exceed the amount actually paid. The BHI claim should show the warrant amount paid to the boarding home or institution; however, the basis for state participation should be only in an amount necessary to effect the maximum state reimbursement in both payments for the month, not to exceed the amount actually paid. If such transfers occur, the maximum state basis for family budget units applies when it is the larger amount (Sec. F-560), except that the basis for state participation on the BHI claim for the partial month shall not exceed \$75. When more than two children in a family are involved the BHI maximum applies, since it is the larger amount.

Example D - Transfer from relative to BHI. Full month paid in advance to relative less than maximum. A child living with the mother is receiving aid in the amount of \$116.00 a month. On January 16 the child is moved to a boarding home and the grant is decreased to \$65.00. On January 1 a warrant is issued to the mother for the full month in the amount of \$116.00. At the end of the month a warrant is issued to the boarding home for 16 days aid in the amount of \$33.55 ($16/31 \times \65.00). The total amount of \$116.00 paid to the mother is shown on the voucher claim as the basis for state participation. Only \$29.00 state basis ($1/31 \times \116.00 maximum state basis less \$116.00 allowed on the voucher claim) may be claimed on the BHI claim.

Example E - Transfer from relative to BHI. Partial month paid to relative in advance - less than maximum. A child living with the mother is receiving aid in the amount of \$66 a month. On January 6 the child is moved to a boarding home and the grant is decreased to \$60. This change is known in advance and on January 1 a warrant is issued to the mother for 5 days aid in the amount of \$10.65 ($5/31 \times \66). At the end of the month a warrant is issued to the boarding home for 26 days aid in the amount of \$50.32 ($26/31 \times \60). The total amount of \$10.65 paid to the mother is shown on the voucher claim as the basis for state participation. The total amount of \$50.32 paid to the boarding home is shown on the BHI claim as the basis for state participation, since the total of the two payments does not exceed the maximum of \$145 for the family budget unit, and the amount paid to the boarding home is within the BHI maximum of \$75.00.

Example F - Transfer from BHI to relative. Partial month paid to relative less than the maximum. Partial month paid to BHI over maximum. A child is living in a boarding home where aid is being paid at the rate of \$90 a month. On February 25 the child is moved to his mother's home where aid is granted in the amount of \$96.00 a month effective February 25. Two warrants are issued, one to the boarding home for 24 days aid in the amount of \$77.14 ($24/28 \times \90) and one to the mother for 4 days aid in the amount of \$13.71 ($4/28 \times \96.00). The total amount of the payment of \$13.71 made to the mother is shown on the voucher claim as the basis for state participation. Only \$75.00 state basis may be claimed on the BHI claim, since the warrant amount of \$77.14 exceeds the BHI maximum of \$75.00.

4. Federal Participation When an Additional Child Becomes Eligible for Aid During the Month.

Federal participation is allowed for an additional child of a family receiving ANC for whom aid is approved to begin during the month, if such child meets all federal requirements of eligibility and the initial payment is not made retroactively.

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5. Federal Participation When an Eligible Relative is Added to an ANC Case During the Month.

Federal participation is allowed for an eligible relative added to an ANC family budget unit during the month, provided the authorization is not effective for a month prior to the month in which the action is taken.

F. TWO OR MORE ANC FAMILY BUDGET UNITS IN ONE HOUSEHOLD

1. Two or More Family Budget Units in the Same Household and There is a Different Payee for Each Family Budget Unit.

Federal participation is available for each needy eligible relative, and each eligible child in each family budget unit. State participation is allowed up to the maximum state basis for each family budget unit.

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2. All of the Children in a Household are in the Care and Control of One Person or the Aid for All of the Children in the Household is Paid to One Person

Federal participation is allowed for the needy eligible relative and for each eligible child in the household. State participation is based on the maximum state basis for the number of children in the household. These maxima apply regardless of whether there is more than one family budget unit in the household and regardless of whether more than one warrant is issued. All cases having the same payee shall be cross-referenced on the payroll.

J. CLAIMING FOR OAS AND ANB RECIPIENTS IN PUBLIC MEDICAL INSTITUTIONS

The OAS and ANB laws provide for payments to patients in public medical institutions for personal and incidental expenses, as well as payments to the institutions for medical care rendered. The total of both payments shall not exceed the amount to which the recipient is currently eligible.

1. Direct Payments to Recipients

Payments to patients shall be made monthly in advance, reported on the regular OAS, ANB and ATD payrolls, and coded "V." There is federal participation in such payments provided the requirements of Sec. F-520 are met.

If a recipient leaves the institution during the month and remains eligible to aid, he will be entitled to receive the remainder of his grant for the month. If he dies or becomes ineligible due to move to non-medical ward, diagnosis of T.B. or psychosis, etc., the remainder of his grant for that month will be paid to the institution.

2. Vendor Payments to Public Medical Institutions

Payments to hospitals shall be made within the month following the month in which care was rendered. Such payments are not considered retroactive. There is federal participation in these vendor payments provided all other federal requirements are met.

Payments to hospitals shall not be reported on the regular OAS, ANB or ATD claims. Separate claims for Payments to Public Medical Institutions are required for each category, OAS, ANB and ATD. For purposes of VPMI claims, the term "current month" on the claim forms is defined as the month immediately preceding that in which the payments to the institutions are made.

(W&IC 116, 1510, 1511, 1512, 1552.2, 1552.3, 1553, 1554, 1556, 1556.5, 1559, 1560, 2020, 2021, 2140, 2183, 2186, 2187, 2189, 2200, 2222.7, 3025, 3075, 3084, 3087.1, 3087.3, 3420, 3432, 3460, 3472, 3480, 3482; FSSA)

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AID CLAIMS

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F-740 REPORTING OF WARRANT CANCELLATIONS

F-740

A. CURRENT CANCELLATIONS

Current cancellations are defined as warrants canceled in the current month which were issued during the current month for the current month or for some prior month(s). Such items shall be reported on the claim for the month in which issued and canceled. Current warrant cancellations shall be listed in state number order by month and shall be reported on a contra roll exactly as claimed on the payroll. Indicate by "Incr" each warrant canceled for which a persons count is not included in the claim.

B. PRIOR CANCELLATIONS

Prior warrant cancellations are defined as warrants canceled in the current month which were issued and claimed in some prior month(s). Prior cancellations shall be reported by month in state number order on contra rolls exactly as originally claimed, or as corrected by SDSW audit. Indicate by "Incr" each warrant canceled for which a persons count is not included in the claim.

Prior cancellation contra rolls shall be grouped and totaled separately for months within the current and prior formula periods, as follows:

ANC Voucher	Current period beginning 10/1/58
ANC-BHI	Current period beginning 10/1/57
OAS, ANB and ATD	Current period beginning 10/1/59
OAS, ANB and ATD-VPMT	Current period beginning 10/1/59
ANC Voucher	Prior period 10/1/57 thru 9/30/58
	Prior period 10/1/56 thru 9/30/57
	Prior period 10/1/52 thru 9/30/56
ANC-BHI	Prior period 10/1/39 thru 9/30/57
OAS, ANB and ATD	Prior period 10/1/58 thru 9/30/59
	Prior period 10/1/56 thru 9/30/58
OAS and ANB	Prior period 10/1/52 thru 9/30/56

C. CLAIM ADJUSTMENT FOR CERTAIN CANCELLATIONS

When reporting the cancellation of one warrant and where a supplemental warrant for the same month remains in effect, an adjustment should be reported on Form ABD, CA 816 (Schedule of Adjustments) to allow the correct persons count and state basis amount for the remaining warrant. See Sec. F-760, Item A.

Example - An OAS recipient received a warrant for \$84.50 (a persons count claimed) on April 1, 1959, and a warrant for \$4.50 (no persons count) on April 15. The \$84.50 warrant was found to be outstanding for over six months, and the persons count was included with the cancellation on the October 1959 claim, therefore, an adjustment should be reported on Form ABD 816, adding a persons count for the \$4.50 warrant still in effect.

(W&IC 116, 1559, 1560, 2140, 2189, 3075, 3087.3, 3460, 3482; FSSA)

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AID CLAIMS

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F-750 REPORTING OF REPAYMENTS

F-750

A. ALLOCATION OF REPAYMENTS TO MONTHS

1. Repayments Receivable and Current Cash Adjustments

All repayments received which are repayments receivable and current cash adjustments (see Sec. F-400) shall be allocated to the month or months during which the overpayment occurred. The amount repaid may represent either total or partial repayment for the month(s) involved. Partial repayments shall be allocated to the earliest month of the period until the overpayment for that month is entirely repaid. Subsequent repayments are allocated in the same manner to successive months thereafter.

2. Voluntary Repayments

A person having no legal obligation to repay any aid paid him may make a voluntary repayment, specify the period to which he wishes the repayment allocated and if he does it shall so be allocated. In the absence of such specification the amount of the voluntary repayment shall be distributed over the entire period during which aid was paid.

B. DISTRIBUTION OF REPAYMENTS

The distribution of repayments as to participating bases and shares is computed on Form ABCD 808, Report of Repayment, as follows:

1. Repayments Receivable and Current Cash Adjustments

Repayments receivable and current cash adjustments (See Sec. F-400) to be reported are applied as grant adjustments to individual months in the overpayment period, beginning with the first month and applying to subsequent months in succession. The entries on Form AECI 808 on Line B "As Claimed" and on Line C "Less: Adjusted claim after this repayment" are computed in the same manner as aid payments are claimed. The entries on Line D "Distribution of Repayment" including persons count, are computed by subtracting the entries on Line C from the entries on Line B. The federal, state, and county shares of repayments applicable to months beginning 10/1/57 for ATD, 10/1/52 for OAS, ANB, ANC voucher, 10/1/47 for APSB, and 10/1/39 for ANC-BHI are not shown on Form ABCD 808 in Columns 4, 5, 6, and 7 since the participating shares are computed on a total basis and/or persons counts on the claim summary sheets for all elements of the monthly claim. Thus only Items 1, 2, 3, and 8 shall be completed for repayments.

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applicable to these periods. For repayments applicable to prior formula periods, (See Sec. F-750-C.2) all columns of Form ABCD 808 shall be completed since the individual shares on each repayment are listed on Form ABC 803, Schedule of Repayments, from which the totals are transferred to the appropriate lines and columns of the claim certification.

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In some ANC cases, the state and the federal bases amounts for a repayment applicable to formula periods prior to 10/1/57 may be larger than the actual amount of the repayment because of the discontinuance of one or more children and the inclusion of county supplemental aid in the new grant.

Example E: An ANC family, consisting of a needy mother and two federally eligible children, was receiving a grant of \$162 (no county supplemental aid). On February 11, 1956, the mother reported that one child, Ruth, was married on January 18, 1956, and left the home. Ruth was ineligible to ANC after January 31. The budgetary need effective February 1 for the mother and one child was determined to be \$147 (\$111 maximum state basis plus \$36 county supplemental aid). The mother refunded the \$15 overpayment for February. The Form ABCD808 is prepared as follows:

	Total Amount	State Basis	Federal Basis	Persons Count Elig. to Fed.
	(1)	(2)	(3)	(8A)
A. For month of February 1956				
B. As claimed-Regular--				
1 elig. relative--				
2 elig. children	\$162.00	\$162.00	\$81.00	1 - 2
C. Less adjusted claim after this repayment	147.00	111.00	60.00	1 - 1
D. Distribution of repayment	\$ 15.00	\$ 51.00	\$21.00	0 - 1

d. Current Adjustment Period, Decreases to Zero and Repayments

In an instance in which both a repayment and a current adjustment period decrease to zero are utilized to adjust for an overpayment, the amount decreased shall not be considered in the computation of the distribution of the repayment.

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Example F - An ANC case, consisting of two federally eligible children (relative not needy), received \$100 for the month of October 1959 and during the month reported income of \$75 which was to be continued each month. In November the children were eligible to receive \$25. Since there was an overpayment of \$75 in October, aid was decreased to "0" November 1 to adjust for \$25 of the overpayment. The family repaid the balance of \$50. In December aid was increased to the amount of \$25. The following explanation is made on Form ABCD808: \$100 was paid in October 1959. \$75 overpayment because of income which will be continuous. Reported October 17. \$25 adjusted by decrease to "0" for November, leaving \$50 overpayment.

The distribution of the cash repayment of \$50 is computed as follows:

	Total Amount (1)	State Basis (2)	Persons Count Elig. to Fed. (8A)
A. For month of October 1959			
B. As claimed regular - 2 ch.	\$100.00	\$100.00	2
C. Less adjusted claim after this repayment	50.00	50.00	2
D. Distribution of repayment	\$ 50.00	\$ 50.00	0

e. Repayments Due to Excess Personal Property

If a repayment due to excess personal property is less than the total amount of aid the recipient received while possessed of excess property, the amounts repaid should not be prorated over all the months during the period of ineligibility, but should be applied to the total amount paid for each successive month, beginning with the first month of the period. The "adjusted claim" (Line C on Form ABCD808) for each successive month should be reduced to "0" before applying any portion of the repayment to a subsequent month.

Example G - An OAS recipient (federally eligible) receiving \$75 a month had personal property in excess of \$1,200 from January through May 1956. Repayment of \$165, the largest amount by which his personal property holdings were excessive, was made. A Form ABCD808 is prepared as follows:

	Total Amount (1)	Federal Excess (3)	Persons Count Elig. to Fed. (8)
A. For month of January 1956			
B. As claimed - Regular	\$ 75.00	\$20.00	1
C. Less: Adjusted claim after this repayment	0	0	0
D. Distribution of Repayment	\$ 75.00	\$20.00	1
A. For month of February 1956			
B. As claimed - Regular	\$ 75.00	\$20.00	1
C. Less: Adjusted claim after this repayment	0	0	0
D. Distribution of repayment	\$ 75.00	\$20.00	1
A. For month of March 1956			
B. As claimed - Regular	\$ 75.00	\$20.00	1
C. Less: Adjusted claim after this repayment	60.00	5.00	1
D. Distribution of repayment	\$ 15.00	\$15.00	0
F. Total repayment	\$165.00	\$55.00	2

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C. REPORTING OF REPAYMENTS ON CLAIMS

1. Reporting on Contra Rolls

Repayments for the current formula periods, and the prior formula periods beginning 10/1/52 for OAS, ANB, ANC voucher and 10/1/39 for ANC - BHI, (Excluding voluntary repayments) are listed from the individual Forms ABCD 808 on Contra Rolls (Form ABD, CA 801, ABD 801 V and CA 801 BHI) in state number order, showing the same information required on the payroll for aid payments (see Item A, Sec. F-730), as well as the month(s) to which each repayment applies.

For OAS, ANB and ATD enter the persons count in the remarks column after each repayment which covers the full amount originally paid for the month or months involved.

Repayment contra rolls shall be grouped and totaled separately for months applicable to the following formula periods:

ANC Voucher	Current period beginning 10/1/58
ANC-BHI	Current period beginning 10/1/57
OAS, ANB and ATD	Current period beginning 10/1/59
OAS, ANB and ATD-VPMI	Current period beginning 10/1/59
ANC Voucher	Prior period 10/1/57 thru 9/30/58
	Prior period 10/1/56 thru 9/30/57
	Prior period 10/1/52 thru 9/30/56
ANC-BHI	Prior period 10/1/39 thru 9/30/57
OAS, ANB and ATD	Prior period 10/1/58 thru 9/30/59
	Prior period 10/1/56 thru 9/30/58
OAS and ANB	Prior period 10/1/52 thru 9/30/56

The distribution on the contra rolls shall be taken from Line F of the individual Forms ABCD 808, Columns 1, 2, 3, and 8 as applicable.

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2. Reporting on Schedule of Repayments

- a. All repayments applicable to the following formula periods, excluding voluntary repayments, are listed from the individual Forms ABCD808, Line F, by formula period on Form ABC 803, Schedule of Repayments. From that form the totals are carried forward to the appropriate lines and columns of the claim certification, Form Ag, Bl, CA 800 and CA 800-BHI.

OAS, ANB, ANC voucher 10/1/48 through 9/30/52
OAS, ANB, ANC voucher 10/1/46 through 9/30/48
OAS, ANB, ANC voucher Prior to 10/1/46
APSB. Prior to 10/1/47
ANC-BHI Prior to 10/1/39

- b. Voluntary repayments for all formula periods are carried forward to Form ABC 803, Schedule of Repayments, from Line F of the individual Forms ABCD 808. From Form ABC 803, the totals are transferred to the claim certifications as special items to be deducted from the totals in the following manner:

Line 9, Columns C, G, H and J of Forms AG, BL and CA 800
Line 5, Columns C, G, H and J of Form DA 800
Line 3, Columns B, D and E of Form CA 800-BHI

No provision is made on the certifications for separate reporting of voluntary repayments due to the small number of repayments which are truly "Voluntary."

- c. Installment repayments begun prior to October 1946. Installment repayments are still being made which were begun prior to October 1946. At that time such payments were computed on a percentage basis in the same manner as prescribed in this section for voluntary repayments. Any installment repayments received for such cases shall continue to be computed on a percentage basis until the overpayment has been repaid in full. Such items will be transferred from individual Forms ABCD808 to a Form ABC 803, Schedule of Repayments, and treated as a special item on the claim certification in the same manner as prescribed above for voluntary repayments.

(W&IC 116, 1504, 1506, 1560, 2007, 2024, 2140, 2222, 2223, 2223.5, 2224, 3007, 3075, 3088, 3406, 3460, 3474; FSSA; AGO 48/44)

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F-760 REPORTING OF ADJUSTMENTS

F-760

A. ADJUSTMENTS FOR THE CURRENT AND PRIOR MONTHS

Form ABD, CA 816, Schedule of Adjustments, shall be used to make necessary claim adjustments to correct individual cases included on the current month's payrolls and contra rolls, rather than to change individual items and page totals. The same form shall be used to effect necessary corrections of errors and omission in claims for prior months, or corrections of unauthorized payments as defined in Sec. F-380.

In setting up the individual corrections on Form ABD, CA 816, the entire item, as it appears on the payroll, is first entered as a minus item in red or in parenthesis. The item as it should be claimed is then entered as a plus item showing all the detail that should have been shown on the payroll. To adjust contra roll items, the same procedure is followed except that the credits and debits are reversed. For OAS, ANB and ATD, VPMI only the amount paid to the institution and the persons count, if any, shall be entered. The remainder of the total adjustment (if any) will be made on Form 816 for the regular aid payroll.

Separate schedules shall be prepared for OAS, ANB, ATD, VPMI, ANC voucher and BHI adjustments covering months within the different formula periods specified on Form ABD, CA 816.

B. ADJUSTMENT FOR ANC TRANSFER CASES

prior to 10/1/57,

In ANC, if a child who had attained one year's residence in the county of residence received non-county or non-county non-federal aid in the county of application, the county's share of ANC paid by the county of application is charged by the SDSW to the county of residence. The adjustment is made in accordance with the dates specified on Form CA 215A, Notification of Transfer under W&IC 1512(c) (See Sec. C-119.30 of the Manual of Policies and Procedures - ANC). The charge is made by a deduction from the state's share of ANC claimed by the county of residence on a current claim, based on a detailed statement of aid paid by the county of application on Form CA 818, which accompanies the claim letter sent to the county of residence.

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C. ADJUSTMENTS TO EFFECT CORRECT CLAIMING OF PARTICIPATION IN CASES OF UNAUTHORIZED PAYMENTS ADJUSTED WITHIN THE CURRENT ADJUSTMENT PERIOD

If an unauthorized payment for a month is adjusted by decreasing the payment for one of the two subsequent months (see Sec. F-520, C, 2), the federal, state, and county participation in the amounts paid for the two months should be the same as if the amounts authorized for each month had been paid. In order to allow the correct participation for the two months, it may be necessary to report an adjustment in the state basis and/or the persons count on the Schedule of Adjustments (Form ABD, CA 816).

Example A: An ANC case, consisting of one child and a needy eligible relative, received \$110 for October 1959. Effective November 1, the grant was decreased to \$55 because of income which was to be continued each month. \$110 was erroneously paid for November. The \$55 unauthorized payment was adjusted by no payment being made in December 1959. No change was made or should have been made in the authorization. In order to allow the correct participation for the two months, as illustrated below, an adjustment should be reported on Form CA 816 on the December claim, increasing the persons count for the two months from 2 to 4.

	Persons Count			
	<u>Eligible Relative</u>	<u>Eligible Children</u>	<u>Warrant Amount</u>	<u>State Basis</u>
<u>AMOUNTS AUTHORIZED</u>				
November 1959	1	1	\$ 55.00	\$ 55.00
December 1959	1	1	55.00	55.00
	2	2	\$110.00	\$110.00
<u>AMOUNTS PAID AND CLAIMED</u>				
November 1959	(1)	(1)	(\$110.00)	(\$110.00)
December 1959	(0)	(0)	(0)	(0)
	(1)	(1)	(\$110.00)	(\$110.00)
<u>ADJUSTMENT</u>	+ 1	+ 1		

(W&IC 116, 1512c, 1559, 1560, 2140, 2189, 3075, 3087.3, 3460, 3482)

CALIFORNIA-SDSW-MANUAL-FISCAL

CONTINUATION SHEET
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(Pursuant to Government Code Section 11380.1)

Fiscal AID CLAIMS F-770

F-770 PREPARATION OF CLAIM SUMMARY DOCUMENTS F-770

A. CLAIM SUMMARY SHEETS, FORMS ABD 802, ABD 802-A, ABD 802-B, AB 802-C, CA 802, 802A, 802B, 802C AND ABD 802V

The Claim Summary Sheets covering the current formula periods, and the prior formula periods indicated on the forms, accumulate in the appropriate lines and columns the persons counts and warrant, bases, and excess amounts from the totals of each payroll, contra roll, and schedule of adjustments applicable to each formula period. From the net totals federal, state, and county shares are computed according to participation status for entry on the Claim Certification, Forms AG, BL, CA and DA 800, ABD 800V and CA 800-BHI.

B. CLAIM CERTIFICATION, FORMS AG, BL, CA, DA AND MC 800, ABD 800V AND CA 800-BHI

The certification shall be accomplished by the affixing of the personal signatures of the county welfare director and the county auditor or representatives of these officers who are properly authorized. The title of the certifying officers shall be shown.

(Section Continued on Next Page)

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F-770 (Continued)

F-770

C. RECONCILIATION STATEMENT FORM ABCD 820

The Reconciliation Statement demonstrates on a total basis that each categorical aid claim includes only amounts authorized to be paid by the county board of supervisors or its duly appointed agent(s). Adequate records are to be maintained in the county to support the figures included in the statement.

Only amounts authorized to be paid or warrants to be cancelled and the persons count included in these authorizations shall be included in Items 1 through 10 of the statement. If there is a difference between the amounts in Item 10 and 11-c, or between persons count in Item 10 and 12-c, this difference shall be stated in Item 13 and/or 14 and shall be explained adequately either below Item 14 or on a separate sheet.

Proper procedure requires that the reconciliation control total be maintained and verified currently as authorizations are approved, resulting in predetermined totals controlling the amounts of aid to be paid and claimed each month. This procedure enables detection of under- or overpayments before warrants are released. It also serves as a signal that there are errors in the aid claims which should be located and corrected, if possible, prior to transmittal of the claim to the SDSW.

The short Form ABCD 820-A has been discontinued as a state supplied form. This form was of some value to smaller agencies with low volume of authorizations and infrequent authorization dates. Counties still using the principles of this form may continue to do so.

(W&IC 116, 1559, 1560, 2140, 2189, 3075, 3087.3, 3450, 3482)

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Fiscal

AID CLAIMS

F-790

F-790

PACKAGING AND TRANSMITTAL OF AID CLAIMS

F-790

All OAS, OAS-VPMI, ANB, ANB-VPMI, APSB, ANC, ANC-BHI, ATD, ATD-VPMI and Medical Care claims filed with the state for aid and medical vendor payments shall be forwarded by the counties so as to be received by Central Office of the SDSW not later than the 8th working day of the month immediately following the month of claim. The ability of the state to prepare quarterly statements of expenditure for the federal government within the required deadline, which is necessary to assure timely monthly advances of federal monies to the counties, depends upon prompt transmittal of county claims.

All claims shall be addressed to SDSW, 722 Capitol Avenue, Sacramento 14, Attention: Fiscal Services. Statistical reports and material for other bureaus or divisions of the Central Office shall not be packaged with claims. Insofar as is possible, each claim shall be transmitted completely at one time in one package. Parts of claims may be submitted separately if:

1. Because of bulk, payrolls for aid claims are sent by express rather than by mail. If payrolls are sent by express, all Certifications, Claim Summary Sheets, and Reconciliation Statements, shall be transmitted by first class mail. A statement shall be included with the mailed documents identifying the material shipped by express and the shipping date.
2. It is not possible to obtain signatures promptly on the certification forms. In this event, an unsigned completed certification (one copy) shall accompany the claim with a note or letter explaining that the signed copies (in triplicate) are to be mailed later (specify date).
3. It is not possible to reconcile the claim in time to enable transmittal by the deadline date. The reconciliation statement may be forwarded later rather than holding up the entire claim. In that event, a note or letter shall be mailed with the claim documents to indicate that the reconciliation statement will be forwarded separately (specify date).

(Continued)

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F-790

AID CLAIMS

Fiscal

F-790 (Continued)

F-790

One complete set of each separate claim (OAS, ANB, APSE, ANC, ANC-BHI, ATD, VPMI and Medical Care) prior to transmittal to the SDSW shall be segregated and, depending upon bulk, shall be fastened together in the following order:

1. Certification
2. Claim Summary Sheets
3. Reconciliation Statement
4. Report of Repayment
5. Incapacitated Parent List
6. Zero Grant List
7. Main Payroll
8. Supplemental payrolls for the current month
9. Supplemental payrolls for prior months
10. Contra rolls for current cancelations
11. Contra rolls for prior cancelations
12. Contra rolls for repayment of aid
13. Schedule of Repayments
14. Schedule of Adjustments

The second and third sets of all documents shall be fastened together and transmitted with the complete claim.

(WIC 116, 1559, 1560, 2140, 2189, 3075, 3087.3, 3460, 3482)

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F-1000 MEDICAL CARE FUNDS

F-1000

A. ADVANCES

SDSW will compute the amount to be advanced to counties each month. Amounts to be advanced for OAS, ANB, ANC, APSB and BHI will be estimated on the basis of past expenditure data. Amounts to be advanced for ATD will represent encumbrances for medical care authorized during the immediate prior month. A statement of cash advances for each program is forwarded to each county in advance of each month. All adjustments between the estimated and actual funds needed for ATD will be shown on the statement of advances for the first month of the second subsequent quarter.

Premium Deposit Funds will be forwarded monthly to the counties by the State Controller. Since this is a pooled fund no designation will be made as to amount of state and federal funds included in the advance and will be considered as state funds for accounting purposes.

B. ACCOUNTABILITY

The basic principles of accountability as specified in Fiscal Manual Section F-200 are applicable to the Medical Care Revolving Fund.

The county shall maintain a Medical Care Revolving Fund into which the premium deposit advances shall be deposited. Deposit will also be made into the Medical Care Revolving Fund of the state and county shares of public assistance funds determined on the basis of the average special need factor.

Payments to vendors for Medical Care services in behalf of OAS, ANB, APSB, ANC, BHI and ATD recipients rendered subsequent to 9/30/59 shall be disbursed from the Medical Care Revolving Fund. Such Medical Care disbursements will only be for services as specified in the Medical Care Manual.

Medical Care services as specified in the Medical Care Manual rendered prior to 10/1/59 not available for payment from the assistance grant as a special need shall be disbursed from the Medical Care Revolving Fund.

Should the county enter into contracts for disbursement of Medical Care Funds, disbursements from the Medical Care Revolving Fund will include disbursements made directly to vendors for services not covered by the contract and payments to the contracting agency excluding payments for administrative expense.

Counties with medical care disbursement contracts wishing to advance Medical Care Revolving Funds to the contracting agency shall provide accounting records necessary to reflect the advances, actual disbursements and adjustment of the differences. When claiming or reporting medical care expenditures the amount of actual expenditures will be reported and claimed.

To enable verification that accountability is properly discharged, the SDSW will, upon request, furnish a transcript to the county of state accounts showing all transactions for the period specified.

(Continued)

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F-1005 FISCAL CONTROLS FOR FUNCTIONAL IMPROVEMENT SERVICES

F-1005

A. General

Throughout the payment and authorization processes for medical care, a series of checks and audit procedures are required. These are specified in Fiscal Manual Section F-1015. In addition, the following requirements apply.

Effective October 1, 1959, functional improvement services are available to recipients of Aid to the Needy Disabled on a selective case basis. Cases will be selected from the review of new applications, re-investigations and upon requests from or on behalf of recipients of ATD. SDSW may, during review of new applications, recommend cases for possible functional improvement services. Cases will be selected generally on the basis of potential for functional improvement which may be gained through the services available in accordance with Medical Care Manual provisions.

In most instances, an evaluation work-up will be authorized on the selected case. After completion of the evaluation work-up, further supplemental authorizations will be issued for cases in which functional improvement of the recipient is feasible and a favorable prognosis for improvement exists. Feasibility is determined by the items found necessary to bring about functional improvement and which are within the money maxima of the program.

B. Required Controls

Authorizations for functional improvement services will be made on Form MC 168 and shall not exceed \$300.00 in any 12 month period for each ATD recipient. The items and amounts authorized will be used by the county as a control over expenditures. A control by individual item is not required. The overcharge on one item may be offset by the undercharge of another item for the same case, except that the cost of the evaluation work-up cannot exceed \$75.00. The total amount expended shall not exceed the amounts of the original authorization plus all supplemental authorizations issued for the same case.

A copy of each MC 168 shall be forwarded to SDSW Central Office at the time authorization is made in order that the amount authorized can be encumbered for purposes of medical care revolving fund advances. (See F-1000-A)

Each original and supplemental authorization, Form MC 168, will be posted as expenditures are made for each item included in the authorization document. When all items authorized on a single authorization document have been provided and payment made, the first copy will be forwarded to the SDSW Central Office. SDSW will make the necessary adjustments in medical care advances, as specified in Fiscal Manual Section F-1000-A.

Controls of medical care payment are based on the authorization document. In order that adequate control of expenditures exists, the authorization documents, Form MC 168, should flow in a uniform and orderly manner between the agencies concerned. Procedure steps to be followed are as specified in Section _____ of the Medical Care Manual.

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Fiscal

MEDICAL CARE

F-1010

F-1010 PAYMENT OF MEDICAL CARE

F-1010

A. AUTHORIZATION OF PAYMENTS

Action by the county board of supervisors or its delegated agent will constitute authorization for payment to vendors for medical services available from the Medical Care Revolving Fund.

Although W&IC Sec. 4551 provides that authorization of the board of supervisors awarding public assistance shall be considered authorization for medical services, it is not interpreted to include authorization for payment but only the recipients eligibility to receive such services.

Authorization to pay medical services is interpreted to be controlled by Sec. 27006 of the Government Code.

B. PAYMENT OF VENDOR CLAIMS

The county shall establish as an objective the payment of vendor claims within 30 days of their receipt.

Such claims shall not be paid unless received by the county or contracting agent within the time limit specified by Sec. MC-052.05 of the Medical Care Manual.

Claims shall be paid by county warrant except for services covered by contract with an outside firm or agency.

(W&IC 114, 115, 116, 1560, 2140, 3060, 3075, 4551, 4554)

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F-1015

MEDICAL CARE

Fiscal

F-1015 AUDIT OF BILLS FOR SERVICES COVERED BY THE MEDICAL CARE TRUST FUND F-1015
PROGRAM.

A. GENERAL

Services covered by the Medical Care Trust Fund Program include all services under the scope and limitations as set forth in Medical Care Manual Secs. MC-031.1 through MC-031.6 regardless of the source of payment. All bills for these services shall be audited to determine:

1. That patient was eligible to aid for the month of service. (Or was included in the family budget unit of an ANC case.)
2. That billing is complete and mathematically accurate. Recipient's signature is not required under several circumstances as set forth in Medical Care Manual Section MC-051. Minor or immaterial omissions may be completed by county; e.g., grand total omitted when all individual items are properly charged.
3. That payment for the specific service covered by billing has not been previously made or scheduled.
4. That authorization, if necessary, was obtained.
5. That treatment for which charge is made is in accordance with authorization. (If authorization required.)
6. That procedures performed or materials dispensed are within the scope and limitations of the program as set forth in Medical Care Manual Sections MC-031.1; MC-031.2; MC-040; MC-041 and MC-046.
7. That charges for procedures or materials are within the maximum amounts allowable as provided in SDSW Schedule of Maximum Allowances. Prescriptions must be audited to both wholesale price and fee schedules.
8. That procedures and treatment are reasonable and proper in relation to patient's medical condition, accepted community practices and the intent and content of the Medical Care Trust Fund Program. That treatment codes designated are correct.
9. Whether source of payment will be from cash grant or Medical Care Revolving Fund.
10. That total amounts of approved bills are in agreement with total amounts disbursed to vendors or contracting agent on consolidated basis.
11. That total amounts claimed on Certification Form MC-800 represent a true total of the sum of individual bills authorized to be paid during the month of claim.

(Continued)

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MEDICAL CARE

F-1015

F-1015 (Continued)

F-1015

12. Medical Care Manual Section MC-031.1 provides that practitioners who do not comply with the rules and procedures contained in the Medical Care Manual shall not use prescription blanks furnished by the SDSW. The auditor who reviews prescriptions in volume for approval for payment is involved with a portion, but not all of the process of enforcement of this rule.

In total, enforcement includes identification, negotiation and claim rejection. The detail payment audit process should be involved only in the latter.

- a. Identification. The county shall employ reasonable methods to identify instances of noncompliance. This may be by spot check of prescriptions to practitioner statements, check of list of known non-participating practitioners to prescriptions, or any other reasonable device that will be effective.
- b. Negotiation. When it is determined that a nonparticipating doctor issues prescriptions the doctor should be contacted and urged to either submit an otherwise complete "No Charge" statement supporting each prescription or desist from issuing prescriptions on the state form. If he does not agree or persists notwithstanding promises to the contrary, notice should be given to the druggist or druggists who appear to fill a substantial proportion of that doctor's prescriptions that prescriptions from that doctor cannot be paid from the Medical Care Revolving Fund.
- c. Claim Rejection. Prescriptions from such doctors submitted by druggists subsequent to receipt of such notice shall be rejected.

Items "a" and "b" should be the responsibility of personnel other than the prescription auditor, since the former would delay payment of bills and the latter is not within his function. It is the duty of the prescription auditor to perform the audit indicated by Item "c".

B. CPS CONTRACT COUNTIES

All audits listed above are performed by CPS on all bills from vendors included in contract except Items 1, 9, 11 and 12, which shall be the responsibility of the county. Item 10 is covered by CPS procedures but duplication of the audit by counties is optional. Counties should not duplicate other audits performed by CPS except that spot check audits may be made to assure county auditor that he may rely on efficiency of contractor's audit.

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Fiscal

F-1020 GOVERNMENT PARTICIPATION

F-1020

A. SOURCE OF PREMIUM DEPOSIT FUNDS

The state and federal governments will share equally in the premium deposits to the Premium Deposit Fund for medical care in behalf of federally eligible recipients of Old Age Security, Aid to Needy Blind, Aid to Needy Children and Aid to Disabled. The state will bear the full cost of premium deposits to the Premium Deposit Fund in behalf of recipients of Aid to Potentially Self-supporting Blind and Aid to Needy Children in Boarding Homes and Institutions, and federally ineligible recipients of OAS, ANB, ANC and ATD.

(W&IC 4552)

B. SOURCE OF ASSISTANCE FUND TRANSFERS

For OAS and ANB the state and the county will share in the assistance fund for transfers into the Medical Care Revolving Fund in the same ratio as for assistance grants (i.e., OAS 6/7 state 1/7 county; ANB 3/4 state and 1/4 county).

C. ADMINISTRATION

The Federal Government will reimburse all matchable expenditures incurred in administration of medical care services, as provided in Sec. F-800, A.

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MEDICAL CARE

Fiscal

F-1020 (Continued)

F-1020

D. BASIS FOR AMOUNTS OF PREMIUM DEPOSITS

Deposits to the Premium Deposit Fund will be made on the basis of the number of "persons counts" for recipients receiving aid in any given month; the number of "persons counts" where the recipient's grant was reduced to "zero" to adjust for an overpayment; and the number of "persons count" for Incapacitated Parents in the ANC family groups.

The Persons Count, for those recipients who receive grants for OAS, ANB, APSB, ATD, ANC and ANC-BHI, will be obtained from the regular assistance claim forms submitted monthly to the SDSW. The persons count for the "zero grant" made in each program, and for the Incapacitated Parent in the ANC family group will be obtained from separate listings. These listings will accompany the monthly claims.

1. The "zero grant" listing will show the NAME, State Number, Total Aid Paid (-0-), and Status of the Case (Regular or Nonfederal). The status will be shown in the remarks column.
2. The Incapacitated Parent listing will show the State Number and Name of Parent. The listing will not include incapacitated parents included in the payroll as eligible relatives, since this would duplicate the persons count.

NOTE: Duplication of persons count must also be eliminated from the ANC Voucher claim (Family Groups) and the ANC-BHI claim. The occasion which may cause duplication of a persons count is where a child in a family group is moved to a boarding home or vice versa during any month and a payment is made to both the family and the boarding home mother. The persons count in these cases is to be included in the ANC Voucher claims (Family Groups) and not in the ANC-BHI claim.

E. BASIS FOR AMOUNTS TRANSFERRED FROM ASSISTANCE FUNDS (OAS AND ANB)

Amounts to be transferred will be the average amount per case as fixed by the State Department of Social Welfare pursuant to Sections 2020.003 and 3084.05 W&IC. To determine the amount to be transferred, the statewide average will be multiplied by the number of recipients as specified in instructions on the individual claiming forms. The number of recipients will be as reported to the state prior to SDSW office audit correction of the claim.

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F-1040

MEDICAL CARE

Fiscal

F-1040 REPAYMENTS

F-1040

There are two general types of repayments in the medical programs.

- a. Those collectible from recipients of aid for overpayment because of ineligibility.
- b. Those collectible from vendors for overpayment of services rendered.

A. REPAYMENTS BY RECIPIENTS

Overpayments to vendors for services rendered to a recipient of assistance for any period of time in which the recipient was ineligible to the aid paid and for which a right to request repayment exists shall be collected from the recipient. Such repayments shall be deposited in the Medical Care Revolving Fund. Basic county responsibilities for recovery and the procedures to be followed are contained in Fiscal Manual Chapter F-400.

In the event the amount collected is not equal to the total expended for public assistance and medical services during the period of ineligibility, an amount shall be deposited in the Medical Care Revolving Fund which bears the same proportion to the total amount collected as the expenditures for medical services bear to the total expended for public assistance and medical services.

The amount deposited to the Welfare and Security Fund shall be reported to the state in the usual manner. The amount deposited to the Medical Care Revolving Fund shall be reported on Certification Form MC-800.

Example: Recipient ineligible to assistance for months of March, April and May. \$85 assistance paid for each of these months. Medical Care vendor payments in behalf of recipient were \$20 for March and \$25 for April. Recipient makes partial repayment of \$70.

Total assistance paid	\$255
Total medical care paid	45
Total aid and medical	\$300

\$255 divided by \$300 = 85%, or \$59.50 deposited to Welfare and Security Fund.

\$45 divided by \$300 = 15%, or \$10.50, deposited to Medical Care Revolving Fund.

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Fiscal

MEDICAL CARE

F-1040

F-1040 (Continued)

F-1040

B. VENDOR REPAYMENTS

Overpayments to vendors for services rendered to a recipient caused by overcharges or items not included in the Medical Care Program for the services rendered shall be collected from the vendor and shall be deposited in the Medical Care Revolving Fund.

1. Basic County Responsibilities

It is the responsibility of the county to verify that medical care vendor payments are made in behalf of eligible recipients in the proper amounts and for only those services as provided for in the Medical Care manual. Reasonable efforts shall be made to recover from the vendor all overpayments caused by any of the above, either through improper application or interpretation. Proper controls for the elimination of overpayments are contained in Fiscal Manual Sections F-1000 C, F-1005 and F-1015.

Counties are also required to maintain and preserve necessary fiscal records to reflect all overpayments and collections.

2. Vendor Repayment Receivable Records

Vendor repayment receivable records will be initiated to record the overpayments and repayments to and from medical care vendors. An account receivable may originate from either of two sources.

- a. In the application of normal medical care controls the county may encounter instances where previous payments have been in excess of the amounts allowable under the fee schedules. Upon discovery of the overpayment, the county will set up the necessary records and proceed to recover the overpayment.
- b. In other instances the overpayment may be discovered by state and federal audits. Audit exceptions involving overpayments to vendors will be set up by the county upon receipt of the audit report. All vendor overpayments will be processed to determine the validity of the exceptions recorded. Protest and clearance material will be submitted to SDSW and acted upon. Vendor overpayment exceptions which have not been deleted will not be adjusted at this time. The county shall exhaust all possible means to effect recovery of these overpayments.

(Continued)

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F-1040

MEDICAL CARE

Fiscal

F-1040 (Continued)

F-1040

3. Plans for Recovery of Vendor Overpayment

Each county shall initiate a definite plan for recovery of vendor overpayments. Minimum requirements for such plans shall include the following:

- a. Within thirty days of discovery of overpayment, establish Vendor Repayment Accounts Receivable and transmit to vendor written request for repayment.
- b. Periodic follow-up at least every 30 days.
- c. If, after a reasonable time, the vendor fails or refuses to repay, take such steps as are necessary to collect. This may be accomplished by any appropriate means, including but not limited to, offset against pending claims from the same vendor, or institution of legal action.

4. Remedial Action on Uncollectible or Uncollected Accounts

If after a reasonable period the county has failed to effect a recovery of the overpayment and the account is classified as uncollectible, the following action will be taken.

- a. If the county has exercised the necessary payment controls but through error the overpayment occurred and the county has made the necessary attempts to recover the overpayment, provisions of Fiscal Manual Section F-480 shall control.
- b. If the county has failed to exercise proper payment controls, audits or recovery procedures either through noncompliance of state rules and regulations or because of inadequate or inefficient administration, the county shall be responsible for the amount of the overpayment and recovery from the county shall be made through administrative action.

(Continued)

CALIFORNIA-SDSW-MANUAL-FISCAL

Rev. 546 replaces Rev. 482

Effective 6/1/59

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e Regulations

F-320 RULES GOVERNING AID WARRANTS

F-320

(Subsection C only)

C. TIME LIMITATION ON WARRANTS

1. Any warrant issued in payment of aid for OAS, ANB, APSB, ATD and ANC (excluding ANC-BHI) is void if not presented to the county treasurer for payment within six months after its date. (Gov. C. 29802)
Every aid warrant shall carry notice of this fact conspicuously on its face in order that persons holding such warrants will present them for payment within the time limit specified. The following wording is recommended: "This warrant is void if not presented to the county treasurer for payment within six months from date."

An ANC-BHI warrant is void if not presented to the county treasurer within two years after its date.

The warrant issue date shall not be counted in computing the last day of the six-month period. If the last day falls on a Sunday or a legal holiday, the day following is considered to be the last day.

Any claim arising from a valid authorization to pay aid resulting in the issuance of an aid warrant becomes void on the same date as the warrant.

2. A recipient of OAS, ANB or APSB, who has in his possession a warrant made payable to him but which has been voided because of the six month limitation, may have issued to him, upon surrender of the voided warrant, a substitute warrant. The substitute warrant will bear the new date of issue but will be in the same amount as the voided warrant.

Provisions for a substitute warrant shall also apply to the legal representative or heir of a deceased recipient. (See F-310.B-2)

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Fiscal

STATE SUBVENTION

F-925

F-925

CLAIMS FOR REIMBURSEMENT OF MATERNITY CARE COSTS UNDER
W&IC 1642.6

F-925

Reimbursement from the Special Deposit Fund (W&IC 1642.5) is available to each county maintaining a licensed county adoption agency for costs incurred after January 1, 1959, in giving prenatal care, delivery and postnatal care including hospitalization for any unmarried mother accepted for service under the provisions of W&IC 1642. Claims for reimbursement will be accepted only from those counties maintaining a licensed county adoption agency which have a plan for maternity care.

A. CLAIMABLE COSTS

Claimable costs include those costs directly attributable to the maternity care furnished. The cost of the mother's care during the normal three to five-day period of hospitalization includes the baby's care. Only costs for those unmarried mothers accepted for service and meeting the requirements of Adoption Secs. AD-222.21 through AD-222.23 are claimable for reimbursement.

Claimable costs shall not include any costs incurred prior to the date the mother was accepted for service nor any costs incurred after termination of service.

B. METHOD OF PAYMENT

Payment shall be made by county warrant payable to the vendor of the service in accordance with the agreement with the licensed physician or surgeon, hospital operated by the Regents of the University of California or a licensed hospital other than a county hospital. No payment shall be made directly to the unmarried mother.

C. METHOD OF CLAIMING

Quarterly claims shall be filed on Forms AD 800 M (in triplicate), AD 801 M (in duplicate) and shall be forwarded to the SDSW by the 8th working day of the month following the end of the quarter.

Claims shall include all cases and expenditures for which full payment has been made within the quarter.

Each item of cost shall be listed on Form AD 801 M opposite the name of the mother receiving the service including the warrant number, date, and period during which services were rendered.

CALIFORNIA-SDSW-MANUAL-FISCAL

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FACE SHEET
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WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

RECEIVED FOR FILING

AUG 18 1959

Division of Administrative Procedure

ENDORSED

APPROVED FOR FILING
(GOV. CODE 11380.2)

AUG 18 1959

Division of Administrative Procedure

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Copy below is hereby certified to be a true and correct copy of regulations adopted, or amended, or an order of repeal by:

~~State Department of Social Welfare~~
(Agency)

Dated: August 17, 1959

By: *[Signature]*

Director
(Title)

FILED

In the office of the Secretary of State
of the State of California

AUG 18 1959

At 3:45 o'clock p.m. In

FRANK M. JORDAN, Secretary of State

[Signature]
Assistant Secretary of State

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A-206.92 SPECIAL NEED FOR EYEGLASSES

A-206.92

If a physician or optometrist recommends the use of eyeglasses, the cost of refractions and of eyeglasses, not to exceed the following maxima, are allowed as special needs.

Refraction	\$15.00
Bifocal lenses (other than cataract) - each lens	10.00
Single vision lenses (other than cataract) - each lens	5.00
Bifocal cataract lenses - each lens	20.00
Single vision cataract lenses - each lens	10.00
Tinted lenses - additional for each lens	2.00
Prism - additional for each lens	2.00
Frames	10.00

(Sales tax and carrying charges, if any, are added to the above maxima.)

Special need may be allowed for more than one type of glasses only when correction for both reading and distance vision is required and two pairs of glasses are recommended by a physician or optometrist because the recipient's physical condition prevents use of bifocal lenses.

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CONTINUATION SHEET
R FILING ADMINISTRATIVE REGULATIONS
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(Pursuant to Government Code Section 11380.1)

Regulations

DETERMINATION OF ELIGIBILITY

A-010.20

A-010.20 COUNTY RESPONSIBILITY FOR APPLICATIONS, REAPPLICATIONS, AND RESTORATIONS

A-010.20

A. DEFINITIONS

1. "Applicant," as referred to herein, includes the person making an initial application for aid (See Sec. A-010.10, Item 2, b.), a reapplication (See Sec. A-010.10, Item 2, d.), or a request for restoration (See Sec. A-010.10, Item 2, c.)
2. "County where the aged person lives," as referred to in W&IC Sec. 2200, Item (a), is the county where such aged person is physically present at the time of application.

Exceptions:

- a. When a living place in another county is being maintained to which the applicant plans to return within 45 days of the date of application, he is considered "to live" in such other county.
- b. An applicant in a state hospital awaiting leave or discharge, is considered "to live" in the county in which he will be physically present upon release from the hospital. If, at time of application, it has not been determined where the patient will "live" upon release, he is considered "to live" in the county from which he was committed to the institution.
- c. When the county in which an applicant normally lives does not have adequate facilities to care for the applicant and as a result the county places him in a nursing home or hospital in another county, the applicant is considered to continue "to live" in the county making the placement for as long as circumstances beyond his control require that he stay outside the county.

B. ACCEPTANCE AND PROCESSING OF APPLICATIONS

The "county where the aged person lives," as defined in "A2" above, shall accept the application, make the necessary investigation (See Sec. A-012.), and grant or deny aid (See Sec. A-014.)

Exception:

When the applicant is an inmate of a nonprofit home or institution to which he was admitted prior to 10-1-59 as provided in W&IC Sec. 2160.5, the county from which he was admitted to such home or institution is responsible for accepting the application, determining eligibility, and if eligibility is established, granting and continuing aid for as long as he remains in such home or institution.

When an applicant is physically present in one county, but "lives" in another county, the county where he is physically present shall assist in completing the application, obtain pertinent information, and immediately send the application to the county in which the applicant lives. The county in which he "lives" shall accept the application, determine eligibility and grant aid if eligibility is established.

When the applicant moves from one county to another to make his home (See Sec. A-016.13.) after the application has been signed but before the county has acted thereon, the county receiving the application shall complete the investigation and authorize aid if eligibility exists. Intercounty transfer is then initiated with the county in which the recipient is making his home. (See Sec. A-016.)

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A-016

DETERMINATION OF ELIGIBILITY

Regulations

A-016.13 RECIPIENT MOVES TO ANOTHER COUNTY TO "MAKE HIS HOME"

A-016.13

A recipient is considered "to make his home" in the county in which he is physically present. When a recipient moves from one county to another pursuant to W&IC Section 2200, Item (b), he is considered "to make his home" in the county to which he has so moved and intercounty transfer arrangements are initiated immediately.

Exceptions:

1. If the recipient is maintaining a living place in some other county than that in which he is physically present and plans to return to that living place within four months, it is considered that he "makes his home" in the county in which such living place is maintained. (The 4 months starts to run from the date the county paying aid determines that the recipient is "maintaining a home" in some county other than that in which he is physically present. If he fails to return to that home within the 4-month period, he is considered to have removed to the county in which he is physically present "to make his home".)
2. When the county in which the recipient "makes his home" does not have adequate facilities to care for the recipient and as a result places him in a nursing home or hospital in another county, the county in which the recipient "makes his home" remains unchanged by such placement for as long as circumstances beyond his control require that he remain in another county.
3. The county in which a recipient "makes his home" is not changed during any absence from the state provided residence outside the state is not established.

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A-021 COUNTY RESPONSIBILITY FOR CASE RECORDS

A-021

The county is responsible for maintaining a case record for each applicant and/or recipient which identifies the individual, his address, and household composition, and which shows:

1. The pertinent information obtained during the investigation conducted in accord with the requirements of Secs. A-012.40 and A-012.50, and the sources from which it was secured.
2. That evidence was evaluated as required in Sec. A-012.60.
3. The needs of the individual and the basis for the decision that he meets, or does not meet, the conditions under which special needs are allowed, and how the money amounts allowed were determined (see Sec. A-201).
4. That income and resources were explored as required by Sec. A-212, and that the amount was computed as specified in Sec. A-212.30, et seq.
5. The original or a copy of all forms completed during the original and subsequent investigations, and relating to any transfer of responsibility for payment of aid between counties except (1) when the date the Ag 239 was mailed is recorded elsewhere, or (2) when the record contains a cross-reference to Form ABD 236 A or B; requests for restoration as defined in Sec. A-010.14, correspondence to and from the county pertinent to the individual's eligibility, his grant, and/or activities toward meeting economic and social needs.
6. The computation of the amount of any overpayment, and the amount or repayment due, if any; a copy of any demands for repayment; the facts regarding the determination of the debtor's ability to repay and collection activity as required by Sec. F-420, et seq., unless this information is recorded centrally elsewhere.
7. A narrative or text containing relevant data (including dates) secured during client or collateral contacts, which does not appear elsewhere in the case record (or which is necessary to augment or reconcile data or information recorded in forms or correspondence); entries to reflect the client's reaction to or understanding of the county's interpretation of his rights and responsibilities.
8. A record of facts reported by the applicant or recipient as required by W&IC 103.3(b).

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Regulations

A-021 (Continued)

A-021

9. The basis for the decision that the individual met, or did not meet, the conditions of eligibility.
10. The basis for holding an application pending eligibility as provided in Sec. A-014.45.
11. The county action granting, denying, changing, suspending, cancelling or discontinuing aid.
12. That service needs of the recipient were explored, the plan developed for meeting such identified needs and progress in development of the service as required by Sec. A-310.20.
13. A record of all medical care the cost of which was met either as a special need or through the Medical Care Fund as provided in Regulation Sections A-205.12 and A-205.13.
14. For a recipient in a public medical institution:
 - (a) Whether or not he requires assistance in making full use of the personal and incidental needs allowance
 - and
 - (b) The basis for the determination
 - (c) If assistance is required, the relative, agency or other person currently assisting him
 - and
 - (d) The plan arrived at with the recipient and worker for the use of the recipient's allowance for personal and incidental needs, and any action taken by the worker, agency or person assisting in the plan. (See Handbook Sec. A-225.)

A-141.10 DEFINITIONS

A-141.10

A public institution is a facility which affords shelter or care, or in which treatment is given for any physical or mental illness, and which is managed in whole or in part by a public instrumentality or is maintained from public funds.

A public medical institution is a) any county, city or district hospital, or unit thereof, which is licensed under H&SC 1422 by the California Department of Public Health; b) a medical unit of the Veteran's Home of California, or c) a medical unit of a federal institution.

A patient is one who is receiving planned, continuing medical treatment, including physician services and nursing care, directed toward improvement in health; or is receiving medical treatment for an illness for which medical measures are required though improvement in health or recovery cannot be expected.

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Regulations

RECORDS, FORMS AND CONTROLS

A-024

A-024

REQUIRED FORMS

A-024

The following forms, completed in accord with instructions for their use, are required when the circumstances to which they relate exist:

- Ag 200 Application for Old Age Security (See Sec. A-011.11)
- Ag 200-B Application by Authorized Representative of Applicant (See Sec. A-011.11)
- Ag 200-c Application for Old Age Security - Supplement for Noncitizens (See Sec. A-122)
- Ag 225 Statement of Responsible Relative Under Old Age Security Law (See Sec. A-153.3)
- Ag 278(a) Authorization for Retroactive Change in Participation Status (See Sec. A-014.30)
- Ag 280 Identification Card (See Sec. A-014.80)
- ABD 231 Certificate of Delivery of Payment of Aid (See Sec. A-141.50)
- ABD 235 Certification of State Department of Mental Hygiene of Applicant's Release from State Hospital (See Sec. A-013)
- ABD 236 A Certification of Patient Status in a Public Medical Institution (See Sec. A-141.40)
- and/or
- ABD 236 B Certification of Patient Status in a Public Medical Institution (See Sec. A-141.40)
- DPA 1 Request for Federal OASI and Nonmedical Disability Information (See Sec. A-213)
- ABCD 215 Notification of Transfer (See Sec. A-114)
- DPA 5 Summary of Letters of Guardianship or Conservatorship (See Secs. A-011.12 and A-011.13)
- DPA 6 State Department of Social Welfare Appeal as to Responsibility for Support (See Sec. A-117.7)
- DPA 8 Notice to Applicant Who Withdraws Application (See Sec. A-014.70)
- 10-611 Application for Search of Census Records (See Handbook Sec. A-102,T)

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Regulations

A-141.20 ELIGIBILITY IN A PUBLIC MEDICAL INSTITUTION

A-141.20

An otherwise eligible person (not excluded by W&IC 2160. h, i, j.) is eligible to receive aid while he is a patient in a public medical institution if he is not involuntarily detained by legal process other than a quarantine requirement. (See Sec. A-206.7, Special Need for Care in a Public Medical Institution and Sec. A-225, Vendor Payments to Public Medical Institutions.)

A-141.40 EVIDENCE OF ELIGIBILITY IN A PUBLIC MEDICAL INSTITUTION

A-141.40

A monthly certification by a responsible official of the public medical institution is required as evidence that the recipient was an eligible patient in a medical ward or unit of the institution and of the monthly charge for care in the institution. (See Sec. A-024.55, Forms AB 236A and 236B) Immediate notification to the county welfare department is required if the patient dies or leaves the medical ward or unit.

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Regulations

A-202 BASIC NEEDS COMMON TO ALL RECIPIENTS

A-202

The following basic items of need are considered to be common to all recipients and to be provided by the maximum OAS grant in the amounts and to the extent specified:

Food	\$28.50 - For food in the normal amount and of a kind necessary to maintain health and vigor.	
Housing and Utilities	21.30 - For adequate, suitable, sanitary housing in a locality chosen by the recipient, and light, water, garbage disposal, refrigeration, and heat needed to maintain health and comfort.	
Household Maintenance	4.50 - For ordinary upkeep and occasional replacement of small items of household equipment and supplies.	
*Clothing	8.70 - For adequate, healthful clothing.	
Transportation	6.00 - For transportation for social and ordinary shopping purposes.	
*Incidentals	13.50 - For hair care, personal toilet articles, dry cleaning, tobacco, etc.	
*Education and Recreation	3.50 - For participation in community activities, adult education courses, hobbies, crafts, reading materials, movies, stationery, postage, etc.	
Medicine Chest Supplies	4.00 - For such medicine chest supplies as cotton, gauze, bandages, aspirin, rubbing alcohol, mineral oil, vaseline, and other over-the-counter items for which no prescription is required and which are ordinarily sought at the recipient's own initiative.	
TOTAL	<u>\$90.00</u>	
*Personal and Incidental Needs (for a patient in a Public Medical Institution beyond a temporary period - See Sec. A-206.7)	\$16.00 - For hair care, shaves, toilet articles, cleansing tissues, tobacco, candy, craft materials, reading materials, stationery, postage, errand service, personal clothing not furnished by the institution, such as robes, slippers and items needed for ambulation and rehabilitation, etc.	

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A-204.27 SPECIAL NEED FOR TELEPHONE

A-204.27

The cost of a telephone is allowed when a telephone is not otherwise readily available on the premises where the recipient resides. The amount allowed shall be the minimum monthly rate for service available to the address where the recipient resides. However, when use of the phone is shared with others in the household, the recipient's share of such minimum rate is allowed.

Exception: If a recipient is physically handicapped or for other bona fide reason needs telephone service the cost of which exceeds the minimum rate, an amount not to exceed that which will meet his actual need, is allowed.

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Regulations**A-205.10 METHODS OF PROVIDING MEDICAL CARE** **A-205.10**

Needed medical care is provided through sources specified by Secs. A-205.11 thru A-205.15 inclusive.

A-205.11 USE OF COMMUNITY RESOURCES **A-205.11**

Community resources which are available without charge to all members of the community and services available to the applicant or recipient at no charge through other state or federal programs are to be utilized in preference to payment from the Medical Care Fund or special need allowance to the recipient.

A-205.12 USE OF PREPAID MEDICAL PLANS **A-205.12**

When all or any portion of a recipient's medical need is covered under any prepaid medical plan or insurance, need is to be met from such medical care plan to the fullest extent possible before any payment from the Medical Care Fund or special need allowance to the recipient (see Sec. A-206.6).

A-205.13 USE OF MEDICAL CARE FUND (SEE APPENDIX, MEDICAL CARE) **A-205.13**

Medical care for which payment may be made on behalf of a recipient from the Medical Care Fund is to be met from the Medical Care Fund only. (See Sec. MC-030) "Recipient" as used herein includes an eligible person for whom, in the month the medical care is received:

1. A cash grant payment is made; or
2. The cash grant payment is withheld or suspended only because of a question concerning the amount of aid to which he is eligible (see Sections A-226.10 and A-226.12); and/or
3. The authorized grant is reduced to Zero to adjust for an overpayment (see Sec. A-227.10).

A-205.14 USE OF SPECIAL NEED ALLOWANCE **A-205.14**

Medical care, for which payment cannot be made on behalf of a recipient from the Medical Care Fund, as provided in MC-020, is allowed as special need within the limitations and conditions specified in Sections A-206 thru A-206.94.

A-205.15 MEDICAL CARE WHEN A PERSON BECOMES A RECIPIENT RETROACTIVELY **A-205.15**

When a person becomes a recipient retroactively, medical needs during the period for which retroactive aid is granted shall be met in the same manner in which they would have been met if the person had been a current recipient at the time the need occurred. (See Sections A-205.11 through A-205.14)

A-206 SPECIAL NEED FOR MEDICAL CARE **A-206**

The items and services which are allowed as special medical needs pursuant to Sec. A-205.14 are listed in Secs. A-206.1 through A-206.94. (Payment for these items and services is not available from the Medical Care Fund.)

Special need is also allowed for items of medical need normally within the scope of the Medical Care Fund (see Sec. MC-030) but for which payment cannot be made on behalf of a recipient from the fund because of his status as a "medical care only recipient." Special need allowances for such medical needs are subject to the same limitations as would apply if the Medical Care Fund were utilized.

(Continued)

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Regulations

A-206 (Continued)

A-206

A "medical care only recipient," as referred to herein, is any recipient whose income (exclusive of an assistance grant) is sufficient to meet his total nonmedical and/or nursing home needs but is insufficient to meet his total need including other medical needs.

A-206.1 SPECIAL NEED FOR DOCTOR'S AND PRACTITIONER'S SERVICES

A-206.1

The practitioner's charge for treatment of illness or other service not within the scope of the Medical Care Fund is allowed as special need up to the fee schedule amounts for the Medical Care Program where such have been established (see MC-040) or in the actual amount when no fee has been set. For this treatment or service the recipient has free choice of any practitioner who meets the requirements set forth in Sec. MC-014 (see Appendix - Medical Care).

A-206.12 SPECIAL NEED FOR DRUGS, THERAPEUTIC PREPARATIONS AND FOOD SUPPLEMENTS

A-206.12

The cost for drugs, therapeutic preparations and/or food supplements dispensed, recommended or prescribed (on Form MC 165) by a practitioner (see MC-014) but not covered by the Medical Care Fund (see MC 031.1, C) is allowed as special need. When the total cost of all such items in the month exceeds \$20, the county will review the diagnosis and treatment plan. Allowance in excess of \$20 in subsequent months is to be made when review indicates that such additional allowance is necessary.

A-206.2 SPECIAL NEED FOR X-RAY THERAPY

A-206.2

The cost of X-ray therapy recommended by a qualified practitioner (MC-014 - Appendix Medical Care), is allowed as special need.

A-206.4 SPECIAL NEED FOR HOME NURSING CARE

A-206.4

The cost of continuous attendance nursing service prescribed by a qualified practitioner and received by a recipient in his own home on a daily, weekly, or monthly basis is allowed as special need when such service is rendered by a registered, licensed, or practical nurse. The amount allowed as special need is based on the usual community rate for such service not to exceed \$200 in any one month. An additional amount, not to exceed \$30 monthly, is allowed as need to cover the cost of food for the nurse.

Exception: The above amounts may be increased when care cannot be obtained within the specified limits and the practitioner recommends against moving the recipient to a nursing home or hospital.

A-206.6 SPECIAL NEED FOR PREPAID MEDICAL OR HOSPITAL CARE

A-206.6

When the recipient is enrolled in a prepaid medical or hospital care plan or carries disability insurance which includes coverage for hospitalization and/or medical care, the cost, not to exceed \$6.00 monthly, is allowed as special need.

(Continued)

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Regulations

A-206.6 (Continued)

A-206.6

Exception: The cost of insurance in which a disability clause is incidental or which has limited coverage insuring only against specified illnesses (e.g., polio, rabies, etc.), is not allowed as special need.

When the item of medical care or service is one for which special need would otherwise be allowed and the prepaid plan or insurance does not cover the item or covers only a portion of it, the cost not met by the prepaid plan is allowed as special need in accord with the limitations specified in Sections A-206 through A-206.94.

A-206.9 SPECIAL NEED FOR DENTAL CARE

A-206.9

When a recipient receives dental care which does not fall within the scope of the Medical Care Fund, the cost, not to exceed the fee schedule applicable to Medical Care Fund payments is allowed. (See Sec. MC-031.1, Item B, Medical Care.)

A-206.94 SPECIAL NEED FOR HEARING AIDS

A-206.94

When an otologist states that the recipient will benefit from use of a hearing aid, the cost, not to exceed the following maxima, is allowed as a special need:

Hearing Aid	-	\$175.00
Monthly upkeep on hearing aid	-	5.00

(Sales tax and carrying charges, if any, are added to the above maxima.)

If the otologist makes a specific recommendation that a recipient can benefit only from a type of hearing aid costing more than the maximum, the actual cost of the type of hearing aid needed is allowed.

Special need is allowed for examination by the otologist when the nature of the examination is such that it does not fall within the scope of the Medical Care Fund; i.e., when its sole purpose is to determine the type of hearing aid needed. In such case the allowance shall not exceed the fee schedule for audiometer testing under the Medical Care Program.

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A-206.7 SPECIAL NEED FOR CARE IN A PUBLIC MEDICAL INSTITUTION A-206.7

Recipient

When a recipient enters a public medical institution as a "patient" the amount charged for care in such institution is allowed as a special need.

When the recipient remains a "patient" in such institution for more than a temporary period, i.e., two calendar months, need at the expiration of such temporary period is determined by allowing the amount charged for care in the institution in lieu of all basic allowances except personal and incidental needs. In addition, \$16.00 is allowed for personal and incidental needs not furnished by the institution. (See Sec. A-202) Medical needs not provided by the institution are also allowed under the conditions and within the maxima specified. (See Sec. A-206 et seq.)

Applicant

When an applicant (or recipient requesting restoration) is a "patient" in a public medical institution at the time aid is granted, need is determined in the manner specified above for the recipient who remains in the institution for more than a temporary period.

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Regulations

AID PAYMENTS

A-221

A-221

AMOUNT OF AID PAYMENT

A-221

Aid is to be paid monthly, subject to the limitations of W&IC 2020, and 2020.002 in the amount determined as follows:

1. If the recipient's current net income received in the month (as determined in accord with Chapter A-21) is \$16 or more, the amount of such income is subtracted from the amount of his total need for the month (as determined in accord with Chapter A-20). The resultant figure, or \$90, whichever is less, is the amount of the grant.
2. If there is no income or the recipient's current net income received in the month is less than \$16, the amount of such income is subtracted from his total need or from \$106, whichever is less. The resultant figure is the amount of the grant.

Exception: The interest payment on a trust deed, mortgage or promissory note received as a result of real property sold pursuant to W&IC Sec. 2165d is earmarked income which, after a home is purchased, must be applied on the home. Therefore, such income is available to apply on other needs only until the month in which the home is purchased and after full payment on the home is completed (see Sec. A-204.05).

Payment is to be authorized, changed, suspended, denied or discontinued by use of Forms ABD 278L and ABD 278M or approved substitutes. (See Sec. A-025.24, Forms ABD 278L and ABD 278M.)

In determining the amount of the aid payment for a particular month, all income and those special needs which existed and were reported before the end of that month are considered.

Exceptions:

1. When the change occurred too late to give the recipient reasonable time to report within the month or the report was not received due to communication difficulties, etc., such change is to be reflected in the aid payment if reported by the end of the following month.
2. When special circumstances, such as the recipient's physical or mental incapacity, make it unreasonable to expect that he could have reported promptly, such change is reflected in the aid payment for the months in which it existed, if reported as soon as could reasonably be expected.

Any deficiency in a previous month between total need and the sum of the grant and the income is not to be carried forward and allowed as need in a subsequent month.

CALIFORNIA-SDSW-MANUAL- OAS

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A-225 VENDOR PAYMENTS TO PUBLIC MEDICAL INSTITUTIONS

A-225

A-225.1 PATIENT ADMITTED TO PUBLIC MEDICAL INSTITUTION WHILE A RECIPIENT A-225.1

When a recipient is a patient in a public medical institution, as defined in Section A-1141.10, the full amount of the grant is paid directly to him for the first two calendar months following his admittance to the institution. If he remains a patient in the public medical institution beyond two calendar months, part or all of the grant is retained for payment to the institution, starting with the third month following his admittance.

Exception: If the recipient is a patient in a public medical institution outside the State of California, the full grant is paid to him even though he remains in the institution for more than two calendar months.

A-225.2 OLD AGE SECURITY GRANTED OR RESTORED TO A PATIENT IN A PUBLIC MEDICAL INSTITUTION

A-225.2

When aid is granted or restored to a patient in a public medical institution and it appears he will remain in such institution, part or all of the grant is retained for payment to the institution, starting with the effective date of the grant.

Exception: If the effective date of the grant precedes the date of admittance to the institution, payment is made in the same manner as if he had been a recipient at the time of admittance (see A-225.1)

A-225.3 COMPUTATION AND DISTRIBUTION OF PAYMENT BETWEEN RECIPIENT AND INSTITUTION

A-225.3

The total aid payment to be made to and/or on behalf of the recipient who is a patient in a public medical institution is determined in accord with Section A-221, Amount of Aid Payment. Income received by the public medical institution on behalf of the recipient, but not available to the recipient for his personal and incidental needs, is considered in determining the amount of the aid payment pursuant to Sec. A-221, but is disregarded in determining distribution of the payment between the recipient and the institution.

When all or a part of the aid payment is to be paid to the institution, the distribution is authorized as follows:

A. Institution Meets All of Recipient's Medical Needs (see Sec. A-206.7)

1. Recipient Has No Income

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 (Pursuant to Government Code Section 11380.1)

Regulations

A-225.3 (Continued)

A-225.3

A direct payment of \$16.00 is made to the recipient for his personal and incidental needs. The balance of the grant is paid to the institution.

2. Recipient Has Income Less Than \$16.00

A direct payment of the difference between his income and \$16.00 is made to the recipient. The balance of the grant is paid to the institution.

3. Recipient Has Income of \$16.00 or More

The entire grant is paid to the institution.

B. Medical Needs Exist Which Are Not Met by the Institution

1. Recipient Has No Income or His Income Is Less Than His Medical Needs Which Are Not Met by the Institution

A direct payment is made to the recipient of \$16.00 plus whichever of the following is less:

- a. The difference between his income, if any, and the amount of his unmet medical needs, or
- b. The amount, if any, by which his income is less than \$16.

2. The Recipient's Income Equals or Exceeds Medical Needs Which Are Not Met by the Institution

A direct payment is made to the recipient of the amount, if any, by which his income, after allowing for medical needs not met by the institution, is less than \$16.00. The balance of the grant is paid to the institution.

A-225.4 RECIPIENT DISCHARGED OR ELIGIBILITY STATUS CHANGED WHILE IN THE INSTITUTION

A-225.4

If the recipient continues to be eligible to receive aid, he receives the full grant for the month in which he is discharged or otherwise leaves the public medical institution; i.e., no portion of the grant is paid to the institution.

If the recipient becomes ineligible to continue receiving aid for any reason during a month while he is a patient in the public medical institution, payment is made to the institution for the full month. Such situations include, but are not limited to the following:

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A-225.4 (Continued)

A-225.4

- A. Recipient is moved to an ineligible unit of the institution; i.e., a custodial ward, a unit established for care of tuberculosis or mental patients.
- B. The recipient's continued care in the institution is the result of a diagnosis of tuberculosis or psychosis.
- C. The recipient dies.

Care in the public medical institution is considered continuous when, within ten days of leaving the institution, the recipient is readmitted for the same ailment; i.e., payment starting with the month following readmittance is made in the same manner as if there had been no discharge or interruption in the care in the institution.

(See Sections A-206.7, Special Need for Care in a Public Medical Institution; and Section A-141.40, Evidence of Eligibility in a Public Medical Institution)

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Regulations

A-227 OVERPAYMENT AND UNDERPAYMENT

A-227

Overpayment occurs if: a) the recipient was not entitled to payment because he did not meet eligibility requirements on the first of the month for which a payment was made; or b) he was eligible but the amount of the payment exceeded the amount to which he was eligible for that month as determined in accord with Sec. A-221.

Underpayment occurs if: a) the applicant or recipient did not receive a payment for which his eligibility has been determined; or b) he received a payment in an amount less than that to which he was eligible for that month as determined in accord with Sec. A-221.

An incorrect payment is not subject to grant adjustment or repayment if:

1. Payment was incorrectly allowed as a special need when payment should have been made from Medical Care Trust Fund, or
2. Payment was incorrectly made from Medical Care Trust Fund when payment should have been made to recipient as a special need. See Sec. A-205.14 - Use of Special Need Allowance, and A-205.13 - Use of Medical Care Fund.

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A-011.20 WHEN APPLICATION TO BE TAKEN

A-011.20

The application, Form Ag 200, shall be signed and acknowledged on all requests for aid at the time the applicant first makes known his need, unless this is reported by telephone or letter. The only exceptions to the requirement that an application be signed when request is made are:

1. When the applicant recognizes that he is ineligible and states that he does not wish to continue with the application
2. When an application or request for restoration has been denied and corrective action is to be taken. (Aid is then granted on the same application or request for restoration which was previously denied. (See Sec. A-227.60, Items 1 and 2(b) re denial actions subject to correction.)
3. When restoration is requested from the same county within one year from the effective date of discontinuance of OAS. (See Sec. A-010.10, Item 2 c. for restorations by another county following discontinuance due to employment.)
4. When aid is granted on appeal to the SDSW.
5. When aid is granted on an intercounty transfer (see Sec. A-016).
6. When an OAS application has been held pending because of apparent eligibility within 90 days from the date of determination of ineligibility. (See A-014.45 - Application Held Pending Eligibility.)

A-014.40 APPLICATION OR REQUEST FOR RESTORATION DENIED

A-014.40

County action shall be taken to deny aid if:

1. Proof of ineligibility has been obtained. Exception: If it is apparent that an applicant will become eligible within 90 days, the application is held pending (see Sec. A-014.45).
2. All reasonable sources of proof of eligibility have been examined without establishing eligibility. Exception: See Sec. A-014.30.
3. The applicant's whereabouts is unknown.
4. The applicant established residence in another state before his eligibility was determined.

(See Sec. A-011.20, Item 2, and Sec. A-227.60, Items 1 and 2b re denial actions subject to correction.)

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A-014.45 APPLICATION HELD PENDING ELIGIBILITY

A-014.45

When, upon investigation of an application or request for restoration, ineligibility is determined but it is apparent the applicant will be eligible within 90 days of such determination, action on the application is withheld and the applicant notified. The date such notification is mailed to the applicant is considered the date on which the county determined the application should be held because of temporary ineligibility. (See Sec. A-014.70 - County Responsibility for Informing Applicants.)

If the applicant becomes eligible within 90 days of the date on which ineligibility was determined, aid is granted from the date of eligibility.

A-014.70 COUNTY RESPONSIBILITY FOR INFORMING APPLICANTS AND RECIPIENTS A-014.70

Pursuant to W&IC Sec. 103.3, 2016, 2019 and 2220.5, the applicant or recipient shall be (a) informed of the eligibility requirements for OAS, (b) notified of any county action which relates to his application or affects aid payment to him and (c) advised of his responsibility for reporting facts material to the determination of his eligibility. All such notifications, advice, etc., shall be in simple understandable language, individualized on the basis of the circumstances in the particular case. Required notifications include:

A. Notice of County Action Granting Aid or Changing the Amount of the Grant.

Immediately following county action, granting aid or changing the amount of the grant, the applicant or recipient shall be notified in writing of the action taken. Form Ag 239, Notice of Action - OAS, or a substitute form containing the same information as appears on both the face and reverse of the Form AG 239, shall be used for this notification. A copy of the Form AG 239 shall be sent the public medical institution when a vendor payment is authorized, changed, or discontinued as provided in Sec. A-225.

B. Notification When Application is Held Pending Eligibility

When an OAS application is being held pending eligibility as provided in Sec. A-014.45, the applicant shall be notified in writing of the determination. Form ABCD 239, Notice of Action, or a substitute form containing the same information as appears on both the face and reverse of the ABCD 239 shall be used for this notification. Form AG 239-C shall also be sent to the applicant as notification of his responsibility to report changes in his circumstances.

C. Notice of County Action Denying, Withholding, or Discontinuing Aid

Immediately following county action denying an application, withholding, canceling or discontinuing aid

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A-014.70 (Continued)

A-014.70

payment, the applicant or recipient shall be notified in writing of the action taken. Form ABCD 239, Notice of Action, or a substitute form containing the same information as appears on both the face and reverse of the ABCD 239 shall be used for this notification. (See Sec. A-226.10 for additional information to be included on the required notification when the aid payment is withheld.)

D. Notification when Application is Withdrawn

When the applicant withdraws his application, Form DPA 8, Notice to Applicant Who Withdraws Application, shall be mailed or given to him unless the county elects to deny the application, in which case a Form ABCD 239 or appropriate substitute, shall be sent to him.

E. Notice to Recipient of His Responsibility

Every recipient shall be notified regularly of his responsibility for reporting facts material to a determination of his eligibility and amount of grant. To accomplish this, Form Ag 239 C, Important Notice to All OAS Recipients, or a substitute form containing the same information, shall be mailed to the recipient as specified below:

1. At the time of the initial warrant on new cases or restorations
2. At least semi-annually on all continuing cases
3. At other times when the county believes notification would be of particular significance, including those instances in which the application is held pending eligibility. (See Sec. A-014.45.)

F. Confirmation of Guidance and/or Suggestions Regarding Sale of Property

When the county gives an applicant or recipient guidance or suggestions regarding the sale of his real or personal property, written confirmation shall be given to the applicant or recipient in accord with the provisions of W&IC Sec. 2019, and a copy of such confirmation filed in the case record.

A-223 BEGINNING DATE OF AID

A-223

Subject to the provisions of W&IC 104.1, 2180.1, 2180.5, 2180.6, 2180.7, 2183.9, 3045 and 3445, the beginning date of aid is determined as follows:

1. When aid is authorized in the same month in which the application is signed or restoration requested, aid is

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A-223 (Continued)

A-223

paid from the date of signing of the application or requesting restoration.

Exceptions:

- (a) If the recipient transfers from one county to another, payment of aid must be continuous and when necessary to make payment continuous, the beginning date of aid in the second county may antedate the signing of the application in the second county.
 - (b) When a recipient of ANB or APSB becomes ineligible and applies for OAS pursuant to code Sections 3045 or 3445, OAS shall begin the first of the month following the effective date of discontinuance of Aid to the Blind.
2. When aid is authorized in a month subsequent to that in which the application is signed or restoration requested, aid is paid from the first day of the month in which authorization action is taken. Exception: When authorization action is taken more than 45 days after the date of application or request for restoration, aid is paid from the first of the month in which authorizing action is taken, or from the first of the month following the expiration of the 45-day period whichever is earlier. However, if the applicant is not eligible until a date subsequent to the date aid would begin under this exception, aid is to begin on the date the applicant became eligible. (See Sections A-014.45, Application Held Pending Eligibility, and A-227.60, Adjustment of Underpayment by Payment of Retroactive Aid.)
- The 45-day period referred to in W&IC 2180.5 begins on the day following that on which an application is signed or restoration is requested. When the 45th calendar day falls on a Sunday or legal holiday, the following day is considered the last day of the 45-day period.
3. Aid which is authorized on an application which was previously denied as provided in Sec. A-227.60 is paid from the date it would have been paid had there been no denial action.
 4. When an application is held pending eligibility, aid is paid from the date eligibility begins. (See Sec. A-014.45.)

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Regulations

A-132.10 DETERMINATION OF VALUE OF REAL PROPERTY

A-132.10

The value of real property holdings is the total verified county assessed value of all real property owned less the total verified amount of encumbrance of record against all of such property. If real property holdings are not assessed and it is impossible to obtain an assessment, one-half of the market value is used.

Exception: When a life lease is evaluated as real property, pursuant to W&IC Section 2163.6, the value is determined in accord with whichever of the following is appropriate:

1. Life Lease Purchased by Assignment of Real Property

The value of the life lease is considered to be the county assessed value of the property assigned (at the time of assignment) less the value of any housing already received under the lease.

2. Life Lease Purchased for Cash or by Assignment of Other Personal Property

The value of the life lease is considered to be one-half of the purchase price of the lease after deducting from such purchase price the value of any housing already received under the lease.

The portion of a contract allocable to housing is defined as a life lease. (See Sec. A-135.10)

When the applicant or recipient and/or spouse is not the sole owner of real property only his or their proportionate share is included in the total value.

A-132.30 REAL PROPERTY ITEMS TO BE INCLUDED

A-132.30

In addition to those items commonly considered to be real property, and those items defined in the W&IC as real property (2165d, 2163.4, 2163.5, 2163.6, 2163.7 and 2163.1) the following items are evaluated as real property:

1. Real property being bought or sold under contract of sale
2. Real property being sold while it is held in escrow
3. Cemetery property held for profit
4. A remainderman's vested future interest in real property.

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A-135.10

PROPERTY

Regulations

A-135.10 PERSONAL PROPERTY ITEMS TO BE INCLUDED

A-135.10

The following items (including those subject to purchase or sale under a conditional sales contract) are evaluated as personal property:

1. Cash, savings accounts, securities, etc.
2. Notes, mortgages and deeds of trust. Exception: See W&IC Sec. 2165d.
3. Motor vehicles not needed for transportation by the applicant or recipient. (See W&IC Sec. 2163.8.) Need exists for a motor vehicle as a means of transportation when there is no other means of transportation available or the recipient is not physically able to use any other type of transportation. However, a motor vehicle, the market value of which exceeds \$1500, is not considered to be a vehicle "needed for transportation."

The market value of a motor vehicle is determined by multiplying the vehicle license fee by 50. Exceptions: The actual market value is used when: (1) The vehicle license fee value of a vehicle otherwise needed for transportation is determined to be in excess of \$1500; or (2) The vehicle license fee value of a vehicle not needed for transportation brings total personal property in excess of the maximum permitted by law (see W&IC Sec. 2163).

4. The cash-surrender value of life insurance, including burial insurance, on the life of the applicant or recipient and on the life of the spouse.
5. Burial trusts or similar funds.
6. Interment plots, crypts, vaults, etc., when retained for use of the owner (see Sec. A-132.30, Item 3). Such a space is valued at \$50 regardless of purchase price.
7. The lessee's interest in a lease of real property for a period of years. Exception: See W&IC 2163.5.
8. Commercial or other business enterprises including farm equipment, livestock and fowl other than that retained for family use only, etc.
9. Interests in firms in receivership.
10. Interests in undistributed estates if the property is available prior to distribution.
11. Interests in trust funds of which the applicant or recipient is beneficiary if the property is in fact available.
12. An interest in property resulting from an advance payment, foundation gift, or property assignment to a fraternal, benevolent or nonprofit institution when, pursuant to an enforceable contract or agreement a refund must be made to the recipient who leaves such institution either voluntarily or involuntarily. The personal property value of such interest is the net amount that would be available as a refund if the recipient were to leave the institution. (For exception, see W&IC Sec. 2163.6 and Regulation Sec. A-132.10.)
13. Any other property which is not real property and which is not excluded under Sec. A-135.30.

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Regulations

A-135.30 PERSONAL PROPERTY ITEMS TO BE EXCLUDED

A-135.30

In addition to the items specifically excluded as personal property in the code (W&IC 2020.01, 2163.1, 2163.2, 2163.4, 2163.5, 2163.6, 2163.8, 2165d) the following items are excluded when evaluating total personal property:

1. Personal property owned by minor children of an applicant or recipient including insurance policies on the lives of minor children.
2. Funds held in an escrow account if the escrow can be revoked only upon the consent of all parties involved.

A-136 DIFFERENTIATION OF PERSONAL PROPERTY AND INCOME

A-136

Nonrecurring lump sum payments which, pursuant to W&IC Sections 2020.01 and 2163.3 are considered personal property upon receipt rather than income, include:

1. Judgments, out of court settlements, and payments received because of compensation laws
2. Inheritances
3. Cash received by the insured from the surrender or maturing of insurance policies
4. Cash received as the beneficiary of insurance including OASI lump-sum death payments
5. Refunds of excess premium payments on National Service Life Insurance
6. Cash received by the recipient and/or his spouse from retirement or pension systems
7. Personal income tax refunds
8. Cash received as a gift.

When, as a result of such lump sum payment (i.e., items 1 through 8 above), personal property holdings on the first of the month following its receipt exceed the amount allowable (see W&IC Section 2163), the excess is considered as income in that month. Any unexpended portion of such income becomes personal property again on the first of the month following that in which it was considered income.

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A-137 ACQUISITION AND CONVERSION OF REAL OR PERSONAL PROPERTY A-137

When a person converts real property to personal property, as provided in W&IC Section 2165d or 2163.6, and plans to use the proceeds to purchase a home for his own occupancy, such proceeds are evaluated as real property, having the same assessed value as the property converted, between the time of receipt of the proceeds and the purchase of a home or the expiration of one year, whichever is earlier.

If a home is purchased and payment therefor completed within a one-year period and the cost of the home is less than the proceeds received from the sale of real property, the balance is evaluated as personal property as of the first of the month following completion of payment for the home. However, if immediate repairs must be made on the purchased property in order to provide a suitable home, allowance for the cost of such repairs is made when determining whether the cost of the home is less than the proceeds received from the sale.

If a home is purchased within a one-year period but payment therefor not completed, any trust deed, promissory note, or mortgage received as proceeds from the prior sale of real property pursuant to W&IC Sec. 2165(d), shall continue to be evaluated as real property for as long as it is retained, provided all payments received thereon, including principal and interest, are applied on the balance due on the home. "Balance due" is limited to principal and interest payments on the home.

The foregoing applies to proceeds received by an applicant or recipient from property sold or otherwise converted prior to application as well as to proceeds received from property converted while an applicant or recipient.

Exception: When the applicant who owns a trust deed, promissory note or mortgage, received from the conversion of real property prior to his application, has already purchased a home at time of application and is applying all payments received on the trust deed, etc., on the purchase of the home, such trust deed, promissory note or mortgage is evaluated as real property without regard to whether:

1. The home was purchased within one year after the prior conversion of real property, or
2. The applicant has applied all payments received prior to application on the purchase of a home.

Real or personal property may be acquired or converted to other forms by a recipient without affecting eligibility if the resultant holdings do not exceed the maximum allowed by the code. (See Sec. A-138.20 for property transfers which do not result in ineligibility.)

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Regulations

RESPONSIBLE RELATIVES

A-153.3

A-153.3 DEGREE OF LIABILITY

A-153.3

Form Ag 225, Statement of Responsible Relative, is used to obtain information essential to the determination of the relative's liability as required under W&IC 2224.

Pursuant to W&IC Sec. 2224, either the board of supervisors or its authorized representative may fix liability at the amount prescribed by the Relative's Contribution Scale. Pursuant to Sec. 2181 only the board of supervisors can fix liability at less than the scale amount.

On return of the completed Form Ag 225 county action is required as follows:

- a. If the county has reason to believe that the information reported by the relative on Form Ag 225 is not accurate, the county is responsible for further investigation into the financial circumstances of the relative before recommendation as to the amount of liability. The consent of the relative involved is to be obtained before any inquiry is made of the employer of the relative.
- b. If Form Ag 225 and any other information obtained as the result of investigation shows no liability for support, a determination of nonliability is made by the county welfare department.
- c. If the Form Ag 225 shows that the relative will contribute as much as or more than the liability prescribed by the Relatives' Contribution Scale, liability is set at the amount prescribed by the Relatives' Contribution Scale.
- d. If the Form Ag 225 shows that the relative will contribute less than his apparent liability or that he will make no contribution, the relative is to be notified of the amount he appears liable to contribute and informed that if he is unable to contribute the specified amount, he may send in additional information regarding his circumstances within a specified period not to exceed 60 days.

If the relative reports any unusual circumstances interfering with his ability to contribute, these are to be taken into consideration in determining liability.

A recommendation as to the amount of liability is made to the board of supervisors not later than the first month following the end of the specified period.

The relative is to be notified of the amount of his fixed liability and the effective date determined pursuant to W&IC Sec. 2224. (See Sec. A-025, Form Ag 246 and 246A.)

A follow-up request shall be sent within 30 days of the mailing of Form Ag 225, Statement of Responsible Relative, if the relative fails to return this form within the time limits specified in W&IC Sec. 2224.

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A-153.3

RESPONSIBLE RELATIVES

Regulations

A-153.3 (Continued)

A-153.3

If a relative fails to return Form Ag 225 within 60 days from the date the form is mailed or otherwise given to him, such failure shall be reported to the Board of Supervisors.

The Board of Supervisors shall refer to the District Attorney or other civil legal officer for action under W&IC Sec. 2224.5 any relative where there is evidence that such relative has knowingly failed to complete and return Form Ag 225.

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Regulations

A-207 SPECIAL NEED TO MEET PAYMENTS ON DEBTS

A-207

Allowance is made for payments on debts under the conditions specified in Sections A-207.1 through A-207.3. Such allowance begins with the month in which the debt is reported.

- Exceptions:
1. Allowance is not made for payment on any debt (secured or unsecured) when such debt resulted from receipt of public assistance, including public medical care or care as a public or private patient in a public medical institution.
 2. When an otherwise allowable debt is reported as soon as could reasonably be expected under the circumstances stated in Regulation Section A-221, allowance for payment on such debt is made beginning with the month following the occurrence which gave rise to the debt.

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Regulations

DETERMINATION OF INCOME

A-211

A-211

INCOME - DEFINITIONS

A-211

Income is any benefit in cash or in kind received as a result of current or past labor or services, business activities, interests in real or personal property or as a contribution from persons, organizations or assistance agencies.

Exceptions:

1. County supplementation is not considered income when the recipient's grant and other income are not sufficient to meet his total need determined within the limits specified in Chapter 20.
2. Certain benefits received as nonrecurring lump sum payments, and proceeds received from sale of property (excluding proceeds from sale of less than an entire holding of livestock, poultry, or timber) are considered personal property rather than income (see Secs. A-136, Differentiation of Personal Property and Income, and A-137, Acquisition and Conversion of Real or Personal Property).

Separate income is a) income derived as a result of an interest in separate property, or, b) income resulting from employment or military service rendered prior to the present marriage.

Community income is

- a. Income derived as a result of an interest in community property, or,
- b. Income resulting from employment or military service performed during the present marriage or being performed at the time of the present marriage.
Exception: If the applicant or recipient has relinquished his community interest in his spouse's earnings by oral or written agreement, such income is separate income of the spouse. If it is determined that the agreement was made for the purpose of qualifying for aid or for a greater amount of aid, such income is considered community income.
- c. Income from the earnings of a minor child, unless the child has been emancipated. (See Sec. A-152, Responsibility of Adult Child.)

Current income is that which is received in the current month regardless of the period over which it accrued.

Exceptions:

1. When all or a portion of a nonrecurring lump sum payment is determined to be income pursuant to W&IC Sections 2020.01 and 2163.3, it is considered "current income" in the month following receipt (see Sec. A-136).
2. Interest payments in decreasing amounts may be averaged.

Any unexpended portion of current income becomes personal property on the first of the month following receipt of the income. Exception: See Sec. A-212.7, Recurring Lump-Sum Income.

Casual income is income which is 1) unpredictable as to amount and time of receipt; 2) of short duration; and 3) of negligible importance in meeting continuing needs under the OAS standard. Such income is not considered in determining the amount of the aid payment.

Income from an inconsequential resource is the net return from an interest in real or personal property which makes no appreciable contribution to the continuing needs of a recipient under the OAS standard. Such income is not considered in determining the amount of the aid payment.

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Regulations

DETERMINATION OF INCOME

A-212.9

A-212.9 INCOME VALUE OF HOMES OWNED AND OCCUPIED

A-212.9

The income value resulting from occupancy of a home which the recipient owns or in which he holds life estate is determined in accordance with the assessed value of the property. The occupancy value to the recipient is based on the full assessed value whether or not he shares occupancy and ownership with others.

Unencumbered homes having a county assessed value of \$500 or less are considered to have an occupancy value of \$3 per month. The value of occupancy is considered to increase at the rate of \$1 per month for each additional \$500 assessed valuation or fraction thereof up to a maximum of \$9 per month.

Encumbered homes are considered to have a net occupancy value determined by subtracting from the gross value of occupancy (as determined above) the required payments, including principal and interest, or the recipient's share of these expenses if the home is community property.

Exceptions:

1. When the total encumbrance payment (principal and interest) is met from the payments (principal and interest) received as a result of real property sold pursuant to W&IC Sec. 2165d, occupancy value is determined in the same manner as for an unencumbered home. If the required encumbrance payment on the home exceeds the payment received as a result of the real property sold, the excess is deducted from gross value of occupancy to determine net value of occupancy.
2. Encumbrance payments for which allowance has already been made as provided in Sec. A-207.2 are not deducted in determining net occupancy value.

When the property owned and occupied by the recipient contains more than one dwelling unit, the value of occupancy is based on the proportion of the assessed value which the unit the recipient occupies bears to the total dwelling space.

The value of occupancy of farm or ranch homes is based on the assessed value of the dwelling and one acre of land.

If the home is not assessed, the value of occupancy is based on the appraised value in accord with the following table:

APPRAISED VALUE	VALUE OF OCCUPANCY
\$ 500 or less	\$ 3.00
501 to 799	4.00
800 to 999	5.00
1,000 or over	6.00

If rent is paid for the land on which the dwelling rests, net occupancy value is determined by subtracting the monthly land rental from the appropriate figure in the table.

(Housing is evaluated in the same manner as free rent (Sec. A-212.40) when:

1. The recipient is living in a home which is the separate property of a spouse who meets the cost of home ownership, such as taxes, upkeep, etc., or
2. The recipient is living in a home or institution where housing is provided under a life lease at no current cost to the recipient (see W&IC Sec. 2163.3 and Regulation Sec. A-132.10).)

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A-224 INITIAL PAYMENTS

A-224

An initial payment is the first payment made on new applications and restorations. (See Secs. A-014.10 and A-014.30) An initial payment may be withheld (see Sec. A-226.10) but is to be cancelled or delivered before the end of the month for which it was authorized. An initial payment is not to be suspended. (See Sec. A-226.12, Suspension of Aid.)

An initial payment is to be made within the month for which aid is granted or restored, or not later in the following month than the time such payments are normally issued under the county's customary fiscal procedure. An initial payment includes aid for prior months if retroactive aid is authorized because:

1. Aid was granted on appeal to the board of supervisors or the SSWB;
2. The SDSW concurs in a county recommendation that retroactive aid be paid to adjust an appeal (see Sec. 055.3, Stipulated Appeals);
3. An application or request for restoration for aid has been denied and corrective action is being taken (see Sec. A-223, Beginning Date of Aid and A-227.60, Adjustment of Underpayment by Authorization of Retroactive Aid).
4. The investigation was not completed within 45 days after the application was signed or restoration requested. (See Appendix Fiscal Manual Sections, Sec. F-520, Federal Participation in Aid Payments.)

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CONTINUATION SHEET
R FILING ADMINISTRATIVE REGULATIONS 5
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

Regulations

A-227.60 ADJUSTMENT OF UNDERPAYMENT BY AUTHORIZATION OF RETROACTIVE AID A-227.60

Definition

Retroactive aid is aid authorized in a subsequent month for some preceding month or months.

ADJUSTMENT BY COUNTY ADMINISTRATIVE ACTION

Underpayment is adjusted by administrative action authorizing payment of retroactive aid under the circumstances prescribed below and with the time limits specified.

1. Underpayment resulting from an administrative error or inadvertence (see Sec. A-227.51).

Such underpayment (including underpayment resulting from a denial or discontinuance due to administrative error or inadvertence) is to be adjusted as provided in W&IC Sec. 103.3, Item f.

2. Underpayment resulting from other causes.

Underpayment resulting from causes other than "administrative error or inadvertence" is to be adjusted in accord with whichever of the following circumstances is appropriate:

- a. Recipient Eligible to a Larger Grant than that Authorized

When aid is paid in the amount authorized but it is later determined that the recipient was eligible for a greater amount (as determined in accord with Sec. A-221), the underpayment is to be adjusted, provided the additional amount due can be authorized before the end of the eighth month following the month for which the recipient was underpaid.

Medical need which can be included in the grant only as a retroactive payment is to be adjusted (subject to the eight-month limitation) regardless of the amount of the underpayment. Underpayment of \$2.00 or less for a particular month resulting from a cause other than such medical need is adjusted only when a necessary increase of \$2.00 or less in the continuing grant (see Sec. A-226, Changes in Amount of Payment) was not made effective until after the second month following that in which the changed circumstances were reported. Payment of retroactive aid in such circumstances shall begin with such second month.

(Continued)

CONTINUATION SHEET
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Regulations

A-227.60 (Continued)

A-227.60

b. Aid Denied or Discontinued to an Eligible Person

When, within six months after date of applicant's or recipient's notification of a denial or discontinuance, the county obtains additional information which indicates eligibility existed for the denied or discontinued payments, or discovers the denial was improper when taken as it was apparent the applicant would be eligible within 90 days (see Sec. A-014.45), the underpayment is to be adjusted provided:

- (1) The applicant or recipient met his responsibility for reporting promptly all facts required of him pursuant to W&IC Sec. 103.3, Item b; and
- (2) The retroactive aid can be authorized before the end of the eighth month following that in which the discontinuance or denial action occurred.

(The authorization is to be in the amount to which the person was eligible and for the period during which he would have received aid if such aid had been granted or continued instead of denied or discontinued.)

c. Incorrect Beginning Date

When aid is not authorized in accord with the code and regulations governing the beginning date and underpayment occurs on a new case, a restoration, an inter-county transfer, or a transfer between OAS, and ANB, such underpayment is to be adjusted provided the amount due can be authorized before the end of the eighth month following the month in which aid is to have begun.

ADJUSTMENT BY THE APPEAL PROCESS

Underpayment (regardless of cause) shall be adjusted by authorization of aid in the amount and for the period ordered by the SSWB or agreed to by the SDSW (see Secs. 055.3 and 055.4).

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CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

The following number changes are to be effective October 1, 1959:

A-205.12 changed to A-205.14

A-205.14 changed to A-205.15

The following section is to be repealed effective October 1, 1959:

A-205.20 Choice of Practitioner

The following sections are to be repealed effective September 19, 1959:

A-207.4 Time Limit for Payments on Debts

A-227.52 Underpayment Due to Erroneous Denial Action

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FACE SHEET
FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

RECEIVED FOR FILING

AUG 18 1959

Division of Administrative Procedure

ENDORSED

APPROVED FOR FILING
(GOV. CODE 11360.2)

AUG 18 1959

Division of Administrative Procedure

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Copy below is hereby certified to be a true and correct copy of regulations adopted, or amended, or an order of repeal by:

State Department of Social Welfare

(Agency)

Dated: August 17, 1959

By:

Director

(Title)

FILED

In the office of the Secretary of State
of the State of California

AUG 18 1959

At 3:45 o'clock p.m.

FRANK M. JORDAN, Secretary of State

Assistant Secretary of State

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B-206.92 SPECIAL NEED FOR EYEGLASSES - ANB-APSB

B-206.92

If a physician or optometrist recommends the use of eyeglasses, the cost of refractions and of eyeglasses, not to exceed the following maxima, are allowed as special needs.

Refraction	\$15.00
Bifocal lenses (other than cataract) - each lens	10.00
Single vision lenses (other than cataract) - each lens	5.00
Bifocal cataract lenses - each lens	20.00
Single vision cataract lenses - each lens	10.00
Tinted lenses - additional for each lens	2.00
Prism - additional for each lens	2.00
Frames	10.00

(Sales tax and carrying charges, if any, are added to the above maxima.)

Special need may be allowed for more than one type of glasses only if correction for both reading and distance vision is required and two pairs of glasses are recommended by a physician or optometrist because the recipient's physical condition prevents use of bifocal lenses.

These Regulations are designated to become effective OCT 1 '59

CONTINUATION SHEET
OR FILING ADMINISTRATIVE REGULATIONS
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(Pursuant to Government Code Section 11380.1)

B-014.70 COUNTY RESPONSIBILITY FOR INFORMING APPLICANTS AND RECIPIENTS - ANB-APSB B-014.7C

The applicant or recipient shall be (a) informed of the eligibility requirements for AB, (b) notified of any county action which relates to his application or affects aid payment to him and (c) advised of his responsibility for reporting facts material to the determination of his eligibility. All such notifications, advice, etc., shall be in simple understandable language, individualized on the basis of the circumstances in the particular case. Required notifications include:

A. NOTICE OF COUNTY ACTION GRANTING AID OR CHANGING THE AMOUNT OF THE GRANT

Immediately following county action, granting aid or changing the amount of the grant, the applicant or recipient shall be notified in writing of the action taken. Form Bl 239, Notice of Action - AB, or a substitute form containing the same information as appears on both the face and reverse of the Form Bl 239, shall be used for this notification. A copy of the Form Bl 239 shall be sent the public medical institution when a vendor payment is authorized, changed or discontinued as provided in Sec. B-225.

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These Regulations are designated to become effective OCT 1 '59

CONTINUATION SHEET
FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

Regulations

B-014.70 (Continued)

B-014.70

B. NOTIFICATION WHEN APPLICATION IS HELD PENDING ELIGIBILITY

If an AB application is being held pending eligibility as provided in Sec. B-014.45, the applicant shall be notified in writing of the determination. Form ABCD 239, Notice of Action, or a substitute form containing the same information as appears on both the face and reverse of the ABCD 239 shall be used for this notification. Form Bl 239-C shall also be sent to the applicant as notification of his responsibility to report changes in his circumstances.

C. NOTICE OF COUNTY ACTION DENYING, WITHHOLDING, OR DISCONTINUING AID

Immediately following county action denying an application, withholding, cancelling or discontinuing aid payment, the applicant or recipient shall be notified in writing of the action taken. Form ABCD 239, Notice of Action, or a substitute form containing the same information as appears on both the face and reverse of the ABCD 239 shall be used for this notification. (See Sec. B-226.10 for additional information to be included on the required notification when the aid payment is withheld.)

D. NOTIFICATION WHEN APPLICATION IS WITHDRAWN

If the applicant withdraws his application, Form DPA 8, Notice to Applicant Who Withdraws Application, shall be mailed or given to him unless the county elects to deny the application, in which case a Form ABCD 239 or appropriate substitute, shall be sent to him.

E. NOTICE TO RECIPIENT OF HIS RESPONSIBILITY

Every recipient shall be notified regularly of his responsibility for reporting facts material to a determination of his eligibility and amount of grant. To accomplish this, Form Bl 239 C, Important Notice to All AB Recipients, or a substitute form containing the same information, shall be mailed to the recipient as specified below:

1. At the time of the initial warrant on new cases or restorations
2. At least semi-annually on all continuing cases
3. At other times when the county believes notification would be of particular significance, including those instances in which the application is held pending eligibility. (See Sec. B-014.45)

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**R FILING ADMINISTRATIVE REGULATIONS
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 (Pursuant to Government Code Section 11380.1)

Regulations

RECORDS, FORMS AND CONTROLS

B-024

B-024

REQUIRED FORMS - ANB - APSB

B-024

The following forms, completed in accord with instructions for their use are required when the circumstances to which they relate exist:

- | | |
|----------|---|
| BL 200 | Application for Aid to the Blind (see Sec. B-011.11) |
| BL 221 | Affidavit Regarding Residence of Applicant (see Sec. B-118.5) |
| BL 225 | Statement of Responsible Relative Under Aid to the Blind Laws (see Sec. B-153.3) |
| BL 227 | Physician's Report of Eye Examination (see Sec. B-192.01) |
| BL 227A | Optometrist's Report of Eye Examination (see Sec. B-192.01) |
| BL 280 | Identification Card (see Sec. B-014.80) |
| ABCD 215 | Notification of Transfer (see Sec. B-114) |
| ABD 231 | Certificate of Delivery of Payment of Aid (see Sec. B-141.50) |
| ABD 235 | Certification from State Department of Mental Hygiene of Applicant's Release from State Hospital (see Sec. B-013) |
| ABD 236A | Certification of Patient Status in a Public Medical Institution - Individual (see Sec. B-141.40) |
| and/or | |
| ABD 236B | Certification of Patient Status in a Public Medical Institution - List (see Sec. B-141.40) |
| DPA 1 | Request for Federal OASI and Nonmedical Disability Information (see Sec. B-213) |
| DPA 5 | Summary of Letters of Guardianship or Conservatorship (see Secs. B-011.12, B-011.13 and B-011.14) |
| DPA 6 | State Department of Social Welfare Appeal as to Responsibility for Support (see Sec. B-017) |
| DPA 8 | Notice to Applicant who Withdraws Application (see Sec. B-014.70) |

 CALIFORNIA-SDSW-MANUAL-AB

CONTINUATION SHEET
**FILING ADMINISTRATIVE REGULATIONS
 WITH THE SECRETARY OF STATE**
 (Pursuant to Government Code Section 11380.1)

B-141.40 EVIDENCE OF ELIGIBILITY IN A PUBLIC MEDICAL INSTITUTION - ANB B-141.40

A monthly certification by a responsible official of the public medical institution is required as evidence that the recipient of ANB was an eligible patient in a medical ward or unit of the institution and of the monthly charge for care in the institution. (See Sec. B-024.55 Forms AB 236A and 236B) Immediate notification to the county welfare department is required if the patient dies or leaves the medical ward or unit.

B-141.10 DEFINITIONS

B-141.10

A public institution is a facility which affords shelter or care, or in which treatment is given for any physical or mental illness, and which is managed in whole or in part by a public instrumentality or is maintained from public funds.

A public medical institution is a) any county, city or district hospital, or unit thereof, which is licensed under H&SC 1422 by the California Department of Public Health; or b) a medical unit of the Veteran's Home of California; or c) a medical unit of a Federal institution.

A patient is one who is receiving planned, continuing medical treatment, including physician services and nursing care, directed toward improvement in health; or is receiving medical treatment for an illness for which medical measures are required although improvement in health or recovery cannot be expected.

B-141.20 ELIGIBILITY IN A PUBLIC MEDICAL INSTITUTION - ANB

B-141.20

In ANB an otherwise eligible person (not excluded by W&IC 3044, first paragraph) is eligible to receive aid while he is a patient in a public medical institution if he is not involuntarily detained by legal process other than a quarantine requirement. (See Secs. B-206.7, Special Need for Care in a Public Medical Institution, and B-225, Vendor Payments to Public Medical Institutions (ANB).)

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CONTINUATION SHEET
**FILING ADMINISTRATIVE REGULATIONS
 WITH THE SECRETARY OF STATE**
 (Pursuant to Government Code Section 11380.1)

B-202 DETERMINATION OF NEED Regulation

B-202 BASIC NEEDS COMMON TO ALL RECIPIENTS - ANB-APSB

B-202

The following basic items of need are considered to be common to all recipients and to be provided by the maximum grant in the amounts and to the extent specified:

Food	\$33.00 - For food in the normal amount and of a kind necessary to maintain health and vigor, and including allowance for waste and shopping in neighborhood stores.
Housing and Utilities Rent \$23.20 Utilities \$6.80)	\$30.00 - For adequate, suitable, sanitary housing in a locality chosen by the recipient, light, water, garbage disposal, refrigeration, and heat needed to maintain health and comfort, and allowing for extensive use of electricity for radio and talking book machine.
Household Maintenance	\$ 5.50 - For ordinary upkeep and occasional replacement of small items of household equipment and supplies, including an allowance for waste, more frequent purchase of supplies, and assistance in household maintenance.
* Clothing	\$10.00 - For adequate, healthful clothing, including an allowance for frequent cleaning and consequent replacement.
Transportation	\$ 3.50 - For transportation for social and ordinary shopping purposes.
* Incidentals	\$15.50 - For shaves, shampoos, hair cuts, personal toilet articles, personal service such as messenger and reading and writing service, dry cleaning, tobacco, etc.
* Education and Recreation	\$ 3.50 - For participation in community activities, adult education courses, hobbies, crafts, reading materials, club dues, stationery, postage, etc.
Medicine Chest Supplies	\$ 4.00 - For such medicine chest supplies as cotton, gauze, bandages, aspirin, rubbing alcohol, mineral oil, vaseline, and other over-the-counter items for which no prescription is required and which are ordinarily bought at the recipient's own initiative.
TOTAL	<u>\$110.00</u>

* Personal and Incidental Needs (for a patient in a Public Medical Institution beyond a temporary period - See Sec. B-206.7)

16.00 - For hair care, shaves, toilet articles, cleansing tissues, tobacco, candy, craft materials, reading materials, stationery, postage, errand service, personal clothing not furnished by the institution, such as robes, slippers and items needed for ambulation and rehabilitation, etc.

CALIFORNIA-EDSW-MANUAL-AB

CONTINUATION SHEET
**FILING ADMINISTRATIVE REGULATION
 WITH THE SECRETARY OF STATE**
 (Pursuant to Government Code Section 11380.1)

Regulations

B-205.10 METHODS OF PROVIDING MEDICAL CARE - ANB-APSB B-205.10

Needed medical care is provided through sources specified by Secs. B-205.11 through B-205.15 inclusive.

B-205.11 USE OF COMMUNITY RESOURCES - ANB-APSB B-205.11

Community resources which are available without charge to all members of the community and services available to the applicant or recipient at no charge through other state or federal programs are to be utilized in preference to payment from the Medical Care Fund or special need allowance to the recipient.

B-205.12 USE OF PREPAID MEDICAL PLANS - ANB-APSB B-205.12

If all or any portion of a recipient's medical need is covered under any prepaid medical plan or insurance, need is to be met from such medical care plan to the fullest extent possible before any payment from the Medical Care Fund or special need allowance to the recipient. (See Sec. B-206.6)

B-205.13 USE OF MEDICAL CARE FUND (See Appendix, Medical Care) - ANB-APSB B-205.13

Medical care for which payment may be made on behalf of a recipient from the Medical Care Fund is to be met from the Medical Care Fund only. (See Section MC-030) "Recipient" as used herein includes an eligible person for whom, in the month the medical care is received:

1. A cash grant payment is made; or
2. The cash grant payment is withheld or suspended only because of a question concerning the amount of aid to which he is eligible (see Sections B-226.10 and B-226.12); and/or
3. The authorized grant is reduced to Zero to adjust for an overpayment (see Section B-227.10).

B-205.14 USE OF SPECIAL NEED ALLOWANCE - ANB-APSB B-205.14

Medical care, for which payment cannot be made on behalf of a recipient from the Medical Care Fund as provided in MC-020, is allowed as special need within the limitations and conditions specified in Sections B-206 through B-206.94.

B-205.15 MEDICAL CARE WHEN A PERSON BECOMES A RECIPIENT RETROACTIVELY - ANB-APSB B-205.15

If a person becomes a recipient retroactively, medical needs during the period for which retroactive aid is granted shall be met in the same manner in which they would have been met if the person had been a current recipient at the time the need occurred (see Secs. B-205.11 through B-205.14).

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Regulations

B-206 SPECIAL NEED FOR MEDICAL CARE - ANB-APSB

B-206

The items and services which are allowed as special medical needs pursuant to Sec. B-205.14 are listed in Secs. B-206.1 thru B-206.94. (Payment for these items and services is not available from the Medical Care Fund.)

Special need is also allowed for items of medical need normally within the scope of the Medical Care Fund (See Section MC-030) but for which payment cannot be made on behalf of a recipient from the fund because of his status as a "medical care only recipient." Special need allowances for such medical needs are subject to the same limitations as would apply if the Medical Care Fund were utilized.

A "medical care only recipient," as referred to herein, is any recipient whose income (exclusive of an assistance grant) is sufficient to meet his total nonmedical and/or nursing home needs but is insufficient to meet his total need including other medical needs.

B-206.1 SPECIAL NEED FOR DOCTOR'S AND PRACTITIONER'S SERVICES - ANB-APSB

B-206.1

The practitioner's charge for treatment of illness or other service not within the scope of the Medical Care Fund is allowed as special need up to the fee schedule amounts for the Medical Care Program where such have been established (see MC-040) or in the actual amount when no fee has been set. For this treatment or service the recipient has free choice of any practitioner who meets the requirements set forth in Section MC-014 (see Appendix - Medical Care).

B-206.12 SPECIAL NEED FOR DRUGS, THERAPEUTIC PREPARATIONS, AND FOOD SUPPLEMENTS - ANB-APSB

B-206.12

The cost for drugs, therapeutic preparations and/or food supplements dispensed, recommended or prescribed (on Form MC 165) by a practitioner (see MC-014) but not covered by the Medical Care Fund (see MC-031.1, C) is allowed as special need. When the total cost of all such items in the month exceeds \$20, the county will review the diagnosis and treatment plan. Allowance in excess of \$20 in subsequent months is to be made when review indicates that such additional allowance is necessary.

B-206.2 SPECIAL NEED FOR X-RAY THERAPY - ANB-APSB

B-206.2

The cost of X-ray therapy recommended by a qualified practitioner (MC-014--Appendix Medical Care), is allowed as special need.

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(Pursuant to Government Code Section 11380.1)

Regulations

B-206.4 SPECIAL NEED FOR HOME NURSING CARE - ANB-APSB

B-206.4

The cost of continuous attendance nursing service prescribed by a qualified practitioner and received by a recipient in his own home on a daily, weekly, or monthly basis is allowed as special need when such service is rendered by a registered, licensed, or practical nurse. The amount allowed as special need is based on the usual community rate for such service not to exceed \$200 in any one month. An additional amount, not to exceed \$30 monthly, is allowed as need to cover the cost of food for the nurse.

Exception: The above amounts may be increased when care cannot be obtained within the specified limits and the practitioner recommends against moving the recipient to a nursing home or hospital.

B-206.6 SPECIAL NEED FOR PREPAID MEDICAL OR HOSPITAL CARE - ANB-APSB

B-206.6

If the recipient is enrolled in a prepaid medical or hospital care plan or carries disability insurance which includes coverage for hospitalization and/or medical care, the cost, not to exceed \$6.00 monthly, is allowed as a special need.

Exception: The cost of insurance in which a disability clause is incidental or which has limited coverage insuring only against specified illnesses (e.g., polio, rabies, etc.) is not allowed as a special need.

If the item of medical care or service is one for which special need would otherwise be allowed and the prepaid plan or insurance does not cover the item or covers only a portion of it, the cost not met by the prepaid plan is allowed as special need in accord with the limitations specified in Sections B-206 through B-206.94.

B-206.9 SPECIAL NEED FOR DENTAL CARE - ANB-APSB

B-206.9

If a recipient receives dental care, which does not fall within the scope of the Medical Care Fund the cost, not to exceed the fee schedule applicable to Medical Care Fund payments, is allowed. (See Sec. MC-031.1, Item B, Medical Care)

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Regulations

B-206.7 SPECIAL NEED FOR CARE IN A PUBLIC MEDICAL INSTITUTION - ANB B-206.7

Recipient

If a recipient enters a public medical institution as a "patient" the amount charged for care in such institution is allowed as a special need.

If the recipient remains a "patient" in such institution for more than a temporary period, i.e., two calendar months, need at the expiration of such temporary period is determined by allowing the amount charged for care in the institution in lieu of all basic allowances except personal and incidental needs. In addition, \$16.00 is allowed for personal and incidental needs not furnished by the institution. (See Sec. B-202.) Medical needs not provided by the institution are also allowed under the conditions and within the maxima specified. (See Secs. B-206, et seq).

Applicant

If an applicant (or recipient requesting restoration) is a "patient" in a public medical institution at the time aid is granted, need is determined in the manner specified above for the recipient who remains in the institution for more than a temporary period. (See Sec. B-225.1 for APSB.)

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B-206.94 SPECIAL NEED FOR HEARING AIDS - ANB-APSB

B-206.94

If an otologist states that the recipient will benefit from use of a hearing aid, the cost, not to exceed the following maxima, is allowed as a special need:

Hearing Aid \$175.00

Monthly upkeep on hearing aid 5.00

(Sales tax and carrying charges, if any, are added to above maxima.)

If the otologist makes a specific recommendation that a recipient can benefit only from a type of hearing aid costing more than the maximum, the actual cost of the type of hearing aid needed is allowed.

Special need is allowed for examination by the otologist if the nature of the examination is such that it does not fall within the scope of the Medical Care Fund; i.e., when its sole purpose is to determine the type of hearing aid needed. In such case the allowance shall not exceed the fee schedule for audiometer testing under the Medical Care Program.

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Regulations

B-211 INCOME - DEFINITIONS - ANB-APSB

B-211

Income is any benefit in cash or in kind received as a result of current or past labor or services, business activities, interests in real or personal property, or as a contribution from persons, organizations or assistance agencies.

Exceptions:

1. County supplementation is not considered income if the recipient's grant and other income are not sufficient to meet his total need determined within the limits specified in Chapter 20.
2. Certain benefits received as nonrecurring lump sum payments, irregular, nonrecurring gifts of money, and proceeds received from sale of property (excluding proceeds from sale of less than an entire holding of livestock, poultry, or timber) are considered personal property rather than income (see Secs. B-136, Differentiation of Personal Property and Income, and B-137, Acquisition and Conversion of Real or Personal Property).

Separate income is a) income derived as a result of an interest in separate property, or, b) income resulting from employment or military service rendered prior to the present marriage, or c) that portion of community income which the wife brings to the community through her efforts.

Community income is:

- a. Income derived as a result of an interest in community property.
- b. Income resulting from employment or military service performed during the present marriage or being performed at the time of the present marriage. Exception: If the applicant or recipient has relinquished his community interest in his spouse's earnings by oral or written agreement, such income is separate income of the spouse. If it is determined that the agreement was made for the purpose of qualifying for aid or for a greater amount of aid, such income is considered community income.
- c. Income from the earnings of a minor child, unless the child has been emancipated. (See Sec. B-150.2.)

Current income is that which is received in the current month regardless of the period over which it accrued. Exceptions: (1) Interest payments in decreasing amounts may be averaged; (2) If all or a portion of a cash gift is determined to be income pursuant to W&IC Secs. 3047.22 and 3447.2, it is considered "current income" in the month following receipt. (See Sec. B-136.)

Any unexpended portion of current income becomes personal property on the first of the month following receipt of the income. Exception: See Sec. B-212.7, Recurring Lump Sum Income - ANB.

Casual income is income which is 1) unpredictable as to amount and time of receipt; 2) of short duration; and 3) of negligible importance in meeting continuing needs under the ANB-APSB standard. Such income is not considered in determining the amount of the aid payment.

(Continued)

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Regulations

B-211 (Continued)

B-211

Income from an inconsequential resource is the net return from an interest in real or personal property which makes no appreciable contribution to the continuing needs of a recipient under the ANB-APSB standard. Such income is not considered in determining the amount of the aid payment.

In ANB exempt earned income is up to and including \$50 a month net income received as wages, salary, commissions, or profit from activities such as business enterprise, farming, etc., in which the applicant/recipient is engaged as a self-employed individual or as an employee. (See Sec. B-212.30, Net Income)

In APSB exempt income is net income from all sources (except casual or inconsequential) up to and including \$1,000 a year, plus 50 percent of any income in excess of \$1,000 during a yearly income period. (See Sec. B-212.30, Net Income)

See Sec. B-136; Differentiation of Personal Property and Income

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 (Pursuant to Government Code Section 11380.1)

Regulations

AID PAYMENTS

B-221

B-221 AMOUNT OF AID PAYMENT - ANB-APSB

B-221

Aid is to be paid monthly in advance, and the amount is determined as follows:

1. ANB: In determining the amount of aid to which an individual is eligible, consideration is first given to:

- a. The amount of net income other than exempt income (see Sec. B-212.10), and
- b. The amount required to meet any special need which the individual has.

The grant is then determined in accord with whichever of the following methods is appropriate:

1. Recipient Has No Nonexempt Income

The grant is \$110 regardless of need.

2. Recipient Has Nonexempt Income But No Special Need

Income is deducted from \$110.

3. Recipient's Nonexempt Income is \$11 a Month or Less

Income is deducted from \$110 regardless of need.

4. Recipient Has a Special Need and the Nonexempt Income is in Excess of \$11 a Month

- a. The first \$11 is deducted from \$110, leaving \$99. In these cases, grant may not exceed \$99.
- b. Compare remaining income (total nonexempt less \$11) with amount of special need:
 - (1) If remaining income is equal to or less than amount of special need, amount of grant is \$99.
 - (2) If remaining income is greater than amount of special need, the difference shall be deducted from \$99 to arrive at amount of grant.

2. APSB: The monthly grant is the maximum amount permitted by the code until exempt income of \$1000 is allowed during any one-year period. Thereafter the monthly grant is dependent upon total need and the amount of nonexempt income, as in ANB. (See Secs. B-212.20 and B-226.)

(Continued)

CALIFORNIA-SDSW-MANUAL-AB

CONTINUATION SHEET
R FILING ADMINISTRATIVE REGULATIONS **15**
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

B-221

AID PAYMENTS

Regulations

B-221 (Continued)

B-221

Payment is to be authorized, changed, suspended, denied or discontinued by use of Forms ABD 278L and ABD 278M or approved substitutes. (See Sec. B-025.24.)

In determining the amount of the ANB payment for a particular month, as well as the APSB payment after allowance for the yearly exempt income (see Sec. B-212.20, Exempt Income - APSB) all nonexempt income and those special needs which existed and were reported before the end of that month are considered.

Exceptions:

1. If the change occurred too late to give the recipient reasonable time to report within the month or the report was not received due to communication difficulties, etc., such change is to be reflected in the aid payment if reported by the end of the following month.
2. If special circumstances, such as the recipient's physical or mental incapacity, make it unreasonable to expect that he could have reported promptly, such change is reflected in the aid payment for the months in which it existed, if reported as soon as could reasonably be expected.

Any deficiency in a previous month between total need and the sum of the grant and the nonexempt income is not to be carried forward and allowed as need in a subsequent month.

CALIFORNIA-SDSW-MANUAL-AB

CONTINUATION SHEET
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 (Pursuant to Government Code Section 11380.1)

Regulation

B-225 VENDOR PAYMENTS TO PUBLIC MEDICAL INSTITUTIONS - ANB

B-225

B-225.1 PATIENT ADMITTED TO PUBLIC MEDICAL INSTITUTION WHILE A RECIPIENT B-225.1

If a recipient is a patient in a public medical institution, as defined in Section B-141.10, the full amount of the grant is paid directly to him for the first two calendar months following his admittance to the institution. If he remains a patient in the public medical institution beyond two calendar months, part or all of the grant is retained for payment to the institution, starting with the third month following his admittance.

Exception: If the recipient is a patient in a public medical institution outside the State of California, the full grant is paid to him even though he remains in the institution for more than two calendar months.

B-225.2 AID TO NEEDY BLIND GRANTED OR RESTORED TO A PATIENT IN A PUBLIC MEDICAL INSTITUTION B-225.2

If aid is granted or restored to a patient in a public medical institution and he will remain in such institution, part or all of the grant is retained for payment to the institution, starting with the effective date of the grant.

Exception: If the effective date of the grant precedes the date of admittance to the institution, payment is made in the same manner as if he had been a recipient at the time of admittance (see B above.)

B-225.3 COMPUTATION AND DISTRIBUTION OF PAYMENT BETWEEN RECIPIENT AND INSTITUTION B-225.3

The total aid payment to be made to and/or on behalf of the recipient who is a patient in a public medical institution is determined in accord with Section B-221, Amount of Aid Payment. Income received by the public medical institution on behalf of the recipient, but not available to the recipient for his personal and incidental needs, is considered in determining the amount of the aid payment pursuant to Section B-221, but is disregarded in determining distribution of the payment between the recipient and the institution.

If all or a part of the aid payment is to be paid to the institution, the distribution is authorized as follows:

A. Institution Meets All of Recipients Medical Needs (See Sec. B-206.7)

1. Recipient Has No Income

A direct payment of \$16.00 is made to the recipient for his personal and incidental needs. The balance of the grant is paid to the institution.

2. Recipient has Income Less than \$16.00

A direct payment of the difference between his income and \$16.00 is made to the recipient and the balance of the grant is paid to the institution.

(Continued)

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Regulations

B-225.3 (Continued)

B-225.3

3. Recipient has Income of \$16.00 or More

The entire grant is paid to the institution. (See B-221, Amount of aid.)

B. Medical Needs Exist Which Are Not Met by the Institution

The recipient is permitted to retain sufficient of his income to meet his personal and incidental expenses (\$16.00) plus whatever additional portion of his income is needed to meet special needs for medical care not furnished by the institution.

B-225.4 RECIPIENT DISCHARGED OR ELIGIBILITY STATUS CHANGED WHILE IN THE INSTITUTION B-225.4

If the recipient continues to be eligible to receive aid, he receives the full grant for the month in which he is discharged or otherwise leaves the public medical institution; i.e., no portion of the grant is paid to the institution.

If the recipient becomes ineligible to continue receiving aid for any reason during a month while he is a patient in the public medical institution, payment is made to the institution for the full month. Such situations include, but are not limited to the following:

1. Recipient is moved to an ineligible unit of the institution; i.e., a custodial ward, a unit established for care of tuberculosis or mental patients, etc.
2. The recipient's continued care in the institution is the result of a diagnosis of tuberculosis or psychosis.
3. The recipient dies.

Care in the public medical institution is considered continuous if, within ten days of leaving the institution, the recipient is readmitted for the same ailment; i.e., payment starting with the month following readmittance is made in the same manner as if there had been no discharge or interruption in the care in the institution.

(See Section B-206.7, Special Need for Care in a Public Medical Institution; and Section B-141.40, Evidence of Eligibility in a Public Medical Institution.)

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Regulations

PREVENTION OF BLINDNESS

B-303.2

B-303.2 TYPES OF TREATMENT - ANB-APSB

B-303.2

The following list indicates the types of treatment which may be authorized by the SDSW and the maximum fee which may be allowed under the program.

FEE SCHEDULE

Cataract, Needling or Discission, operation for.....	\$ 50.00
Cataract, operation for (to include all postoperative care within 90 to 120 days following surgery, as well as final report and refraction.....)	175.00
Cataract, operation for (to include up to 15 days postoperative care and consultation if requested by local eye physician within 120 postoperative days).....	115.00
Corneal Surgery - Nonpenetrating (to include all postoperative care within 90 to 120 days following surgery).....	150.00
Corneal Surgery - Penetrating (to include 3 mos. postoperative care).....	250.00
Ectropion, operation for.....	50.00
Entropion, operation for.....	50.00
Enucleation of Eye, if necessary to preserve vision in remaining eye.....	75.00
Glaucoma, surgery for (other than simple Iridectomy).....	90.00
Iridectomy, Simple Iridectomy.....	75.00
Lacrymal Sac, excision of, or Dacryocystotomy.....	50.00
Pterygium, removal of, or other external eye surgery.....up to	40.00
Retinal Detachment, correction of, if required in postsurgical cases under Prevention of Blindness program.....	150.00
Retinal Detachment occurring outside of the Prevention of Blindness program may be included upon the recommendation of the State Ophthalmologist.	
Each surgery fee except as indicated includes up to 15 days postoperative care.	
Office visits - \$5.00 each, following 15 days postoperative period (except if surgery fee includes postoperative observation)	
Diagnostic examination (when surgery not performed).....	15.00
Fee for diagnostic examination included in surgery fee when surgery follows.	

PHYSICAL EXAMINATION

Physical examination to determine feasibility for eye surgery.....	10.00
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POSTOPERATIVE TREATMENT IN LOCAL COMMUNITIES

Postoperative care and report by eye physician other than the operating surgeon (each visit).....	5.00
Postoperative refraction with prescription.....	15.00

TREATMENT ONLY
(No surgery involved)

Initial diagnostic examination.....	15.00
Observation and Report.....	5.00

(Continued)

CALIFORNIA-SDSW-MANUAL-AB

Issue No. 30-6

CONTINUATION SHEET
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B-303.2 PREVENTION OF BLINDNESS Regulations

B-303.2 (Continued) B-303.2

REFRACTIONS AND EYEGLASSES

If a physician or optometrist prescribes eyeglasses, the cost of refractions and of eyeglasses, not to exceed the following maxima, are allowable:

Refraction	-	\$15.00
Bifocal lenses (other than cataract)	- each lens	10.00
Single vision lenses (other than cataract)	- each lens	5.00
Bifocal cataract lenses	- each lens	20.00
Single vision cataract lenses	- each lens	10.00
Tinted lenses	- additional for each lens	2.00
Prism	- additional for each lens	2.00
Frames	-	10.00

(Sales tax and carrying charges, if any, are added to the above maxima.)

Only one pair of glasses is allowed except if correction for both reading and distance vision is required and two pairs of glasses are prescribed by a physician or optometrist because the recipient's physical condition prevents the use of bifocal lenses.

OTHER COSTS

Consultation or anesthetist service, if required	As charged
Hospital items	As charged
Boarding home items, if required	As charged
Miscellaneous items, if required	As charged
Transportation items, if required	As paid
Personal items, such as shaves, haircuts, telephone calls, personal service, etc.	As paid
	Not to exceed an average of \$1.00 per day for the time the patient is in the hospital or nursing home.

If an ophthalmologist performs two or more eye operations at a hospital or clinic not located in his city of residence, payment of his traveling expenses may be authorized in accordance with the rules of the Board of Control applicable to state employees. (See Sec. B-303.3)

Since glaucoma is a condition which frequently requires emergent action, treatment should be provided through local medical facilities. If no local resources are available, the SDSW may provide glaucoma treatment and/or surgery.

If medical complications not directly related to the eye treatment or surgery should develop while a person is under care of SDSW, only emergency measures can be authorized until the individual or county arranges for necessary care.

CALIFORNIA-SDSW-MANUAL-AB Revision Effective

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Regulation

B-011.20 WHEN APPLICATION TO BE TAKEN - ANB - APSB

B-011.20

The application, Form Bl 200, shall be signed and acknowledged on all requests for aid at the time the applicant first makes known his need, unless this is reported by telephone or letter. The only exceptions to the requirement that an application be signed when request is made are:

1. If the applicant recognizes that he is ineligible and states that he does not wish to continue with the application.
2. If the applicant makes a specific request to delay the signing of the application.
3. If an application or request for restoration was erroneously denied, or aid was erroneously discontinued, and corrective action is to be taken. (Aid is then granted on the same application or request for restoration which was previously denied.) (See Sec. B-227.60)
4. If restoration is requested within one year from the effective date of discontinuance.
5. If aid is granted on appeal to the SSWB.
6. If payment of aid is being transferred from one county to another.
7. If payment of aid is being changed from ANB to APSB, or vice versa.
8. If the SDSW finds, upon review of subsequent eye examination(s), that an individual whose aid had been previously denied, because of insufficient blindness, is eligible as to degree of blindness.
9. If the SDSW finds, upon review of subsequent eye examination(s), that an individual whose aid had been discontinued for less than twelve months, because of insufficient blindness, is eligible as to degree of blindness. (See Sec. B-192.03)
10. If an ANB application has been held pending because of apparent eligibility within 90 days from the date of determination of ineligibility. (See B-014.45 - Application Held Pending Eligibility)

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**CONTINUATION SHEET
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Regulations

B-014.40 APPLICATION OR REQUEST FOR RESTORATION DENIED - ANB - APSB B-014.40

County action shall be taken to deny aid if:

1. Proof of ineligibility has been obtained. Exception:
If it is apparent that an applicant for ANB will become eligible within 90 days, the application is held pending. (See Sec. B-014.45)
2. All reasonable sources of proof of eligibility have been examined without establishing eligibility.
3. The applicant's whereabouts is unknown.
4. The applicant established residence in another state before his eligibility was determined.

(See secs. B-011.20, Item 3, and B-227.60, Items 1 and 2(b) re denial action subject to correction.)

B-014.45 APPLICATION HELD PENDING ELIGIBILITY - ANB

B-014.45

If, upon investigation of an application for ANB, ineligibility is established but it is apparent that the applicant will probably become eligible within 90 days, the county shall hold the application pending eligibility and shall so notify the applicant. The date such notification is mailed to the applicant is considered the date on which the county determined the application should be held because of temporary ineligibility. (See B-014.70, County Responsibility for Informing Applicants and Recipients.) If within 90 days the applicant becomes eligible, aid shall be granted from the date of eligibility.

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Regulations

RECORDS, FORMS AND CONTROLS

B-021

B-021

COUNTY RESPONSIBILITY FOR CASE RECORDS - ANB-APSB

B-021

The county is responsible for maintaining a case record for each applicant and/or recipient which identifies the individual, his address, and household composition, and which shows:

1. The pertinent information obtained during the investigation conducted in accord with the requirements of Secs. B-012.40 and B-012.50, and the sources from which it was secured.
2. That information and evidence were evaluated as required in Sec. B-012.60.
3. The needs of the individual and the basis for the decision that he meets, or did not meet, the conditions under which special needs are allowed, and how the money amounts allowed were determined (see Chapter 20).
4. That income and resources were explored as required by Sec. B-212, and that the amount was computed as specified in Chapter 21.
5. The original or a copy of all forms completed during the original and subsequent investigations, and relating to any transfer of responsibility for payment of aid between counties except (1) when the date the BI 239 was mailed is recorded elsewhere, or (2) when the record contains a cross reference to Form ABD 236 A or B; requests for restoration as defined in Sec. B-010.14, correspondence to and from the county pertinent to the individual's eligibility, his grant, and/or activities toward meeting economic and social needs.
6. Information concerning plans for rehabilitation, physical, economic, social including referrals to other agencies.
7. In APSB, the individual's plan for self-support and progress toward this goal.
8. The computation of the amount of any overpayment, and the amount of repayment due, if any; a copy of any demands for repayment; the facts regarding the determination of the debtor's ability to repay and collection activity as required by Secs. F-420, et seq., unless this information is recorded centrally elsewhere. (See Appendix, Fiscal Manual Sections)
9. A narrative or text containing relevant data (including dates) secured during client or collateral contacts, which does not appear elsewhere in the case record (or which is necessary to augment or reconcile data or information recorded in forms or correspondence); entries to reflect the client's reaction to or understanding of the county's interpretation of his rights and responsibilities.
10. A record of facts reported by the applicant or recipient as required by W&IC 103.3(b).
11. The basis for the decision that the individual met, or did not meet the conditions of eligibility.
12. The basis for holding an application pending eligibility as provided in Sec. B-014.45.

(Continued)

CALIFORNIA-SDSW-MANUAL-AB

CONTINUATION SHEET
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B-021 (Continued)

B-021

13. The basis for the determination of the program (ANB or APSB) which is more appropriate for the applicant/recipient. (See Secs. B-313 and B-025.)
14. The county action granting, denying, changing, suspending, canceling or discontinuing aid.
15. A record of all medical care the cost of which was met either as a special need or through the Medical Care Fund as provided in Regulation Secs. B-205.12 and B-205.13.
16. For a recipient in a public medical institution:
 - (a) Whether or not he requires assistance in making full use of the personal and incidental needs allowance
and
 - (b) The basis for the determination
 - (c) If assistance is required, the relative, agency or other person currently assisting him
and
 - (d) The plan arrived at with the recipient and worker for the use of the recipient's allowance for personal and incidental needs, and any action taken by the worker, agency or person assisting in the plan. (See Handbook Sec. B-225.

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Regulations

B-207 SPECIAL NEED TO MEET PAYMENTS ON DEBTS - ANB-APSB

B-207

Allowance is made for payments on debts under the conditions specified in Sections B-207.1 through B-207.3. Such allowance begins with the month in which the debt is reported.

- Exceptions:
1. Allowance is not made for payment on any debt (secured or unsecured) if such debt resulted from receipt of public assistance, including public medical care or care as a public or private patient in a public medical institution.
 2. If an otherwise allowable debt is reported as soon as could reasonably be expected under the circumstances stated in Regulation Section B-221, allowance for payment on such debt is made beginning with the month following the occurrence which gave rise to the debt.

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Regulations

B-223 BEGINNING DATE OF AID - ANB-APSB

B-223

Subject to the provisions of W&IC 104.1, 3078.3, 3082, 3082.2, 3084, 3088.5, 3474.5, 3475, the beginning date of aid is determined as follows:

1. If aid is authorized in the same month in which the application is signed or restoration requested, aid is paid from the date of signing of the application or request for restoration. Exceptions: (1) If the recipient transfers from one county to another, the beginning date of aid in the second county may antedate the signing of the application in the second county; (2) If a transfer from OAS to ANB-APSB, or ANB-APSB to OAS, is authorized, aid may begin the first of the month following the month in which such transfer was authorized.
2. If aid is authorized in a month subsequent to that in which the application is signed, aid is paid from the first day of the month in which authorization action is taken. Exception: If authorization action is taken more than 45 days after the date of application, aid is paid from the first of the month in which authorizing action is taken, or from the first of the month following the expiration of the 45-day period, whichever is earlier. However, if eligibility is not established until a date subsequent to the date aid would begin under this exception, aid is to begin on the date the applicant became eligible. (See Sec. B-014.45, Application Held Pending Eligibility; B-227.60, Adjustment of Underpayment by Payment of Retroactive Aid)

The 45-day period begins on the day following that on which an application is signed. If the 45th calendar day falls on a Sunday or legal holiday, the following day is considered the last day of the 45-day period.

3. If an application was improperly denied and such erroneous action is being corrected, aid is paid from the date it would have been paid had there been no denial action.
4. If ANB is authorized in a month subsequent to that in which restoration is requested, aid is paid from the first day of the month immediately following the date of the request.
5. If APSB is authorized in a month subsequent to that in which restoration is requested, aid is paid from the date of signing the request for restoration.

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Regulations

B-223 (Continued)

B-223

6. If eligibility is dependent upon medical evidence (eye and/or neuropsychiatric examination), the condition described in such evidence shall be considered to have existed from the first day of the month in which the determining medical examination is made. (See Chapter 19)
7. Aid which is authorized on an application which was previously denied as provided in Sec. B-227.60, is paid from the date it would have been paid had there been no denial action.
8. If an ANB application is held pending eligibility, aid is paid from the date eligibility begins. (See Sec. B-014.45)

B-224 INITIAL PAYMENT - ANB-APSB

B-224

An initial payment is the first payment made on new applications and restorations. (See Secs. B-014.10 and B-014.30) An initial payment may be withheld (see Sec. B-226.10) but is to be cancelled or delivered before the end of the month for which it was authorized. An initial payment is not to be suspended. (See Sec. B-226.12)

An initial payment is to be made within the month for which aid is granted or restored, or not later in the following month than the time such payments are normally issued under the county's customary fiscal procedure. An initial payment includes aid for prior months if retroactive aid is authorized because:

1. Aid was granted on appeal to the SSWB or the board of supervisors;
2. The SDSW concurs in a county recommendation that retroactive aid be paid to adjust an appeal (see Sec. 055.3, Stipulated Appeals); or in appeals based on degree of blindness, the county concurs in the recommendation of the SDSW.
3. An application for aid or request for restoration has been improperly denied and corrective action is being taken (see Sec. B-223, Beginning Date of Aid and B-227.60, Adjustment of Underpayment by Authorization of Retroactive Aid).
4. The investigation was not completed within 45 days after the application was signed. (See Appendix Fiscal Manual Sections, Sec. F-520)
5. The investigation of a request for restoration for ANB was not completed within the month following the date of request.
6. The investigation of a request for restoration for APSB was not completed within the month in which restoration was requested.

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Regulations

AID PAYMENTS

B-227.20

B-227

OVERPAYMENT AND UNDERPAYMENT - ANB-APSB

B-227

Overpayment occurs if a) the recipient was not entitled to payment because he did not meet eligibility requirements on the first of the month for which a payment was made, or b) he was eligible but the amount of the payment exceeded the amount to which he was eligible for that month as determined in accord with Sec. B-221.

Underpayment occurs if a) the applicant or recipient did not receive a payment for which his eligibility had been determined; or, b) he received a payment in an amount less than the amount to which he was eligible for that month as determined in accord with Sec. B-221.

An incorrect payment is not subject to grant adjustment or repayment if:

1. Payment was incorrectly allowed as a special need if payment should have been made from Medical Care Trust Fund, or
2. Payment was incorrectly made from Medical Care Trust Fund if payment should have been made to recipient as a special need.

See Secs. B-205.14, Use of Special Need Allowance and B-205.13, Use of Medical Care Fund.

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Regulations

B-227.60 ADJUSTMENT OF UNDERPAYMENT BY AUTHORIZATION OF
 RETROACTIVE AID - ANB-APSB

B-227.60

Definition

Retroactive aid is aid authorized in a subsequent month for some preceding month or months.

ADJUSTMENT BY COUNTY ADMINISTRATIVE ACTION

Underpayment is adjusted by administrative action authorizing payment of retroactive aid under the circumstances prescribed below and within the time limits specified.

1. Underpayment resulting from an administrative error or inadvertence (see Sec. B-227.51).

Such underpayment (including underpayment resulting from a denial or discontinuance due to administrative error or inadvertence) is to be adjusted as provided in W&IC Sec. 103.3, Item f.

2. Underpayment resulting from other causes.

Underpayment resulting from causes other than "administrative error or inadvertence" is to be adjusted in accord with whichever of the following circumstances is appropriate:

- a. Recipient Eligible to a Larger Grant than that Authorized

If aid is paid in the amount authorized but it is later determined that the recipient was eligible for a greater amount (as determined in accord with Sec. B-221), the underpayment is to be adjusted, provided the additional amount due can be authorized before the end of the eighth month following the month for which the recipient was underpaid.

Medical need which can be included in the grant only as a retroactive payment is to be adjusted (subject to the eight-month limitation) regardless of the amount of the underpayment. Underpayment of \$2.00 or less for a particular month resulting from a cause other than such medical need is adjusted only when a necessary increase of \$2.00 or less in the continuing grant (see Sec. B-226, Changes in Amount of Payment) was not made effective until after the second month following that in which the changed circumstances were reported. Payment of retroactive aid in such circumstances shall begin with such second month.

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Regulations

B-227.60 (Continued)

B-227.60

b. Aid Denied or Discontinued to an Eligible Person

If within six months after date of applicant's or recipient's notification of a proper denial or discontinuance, the county obtains additional information which indicates eligibility existed for the denied or discontinued payments, or discovers the denial was improper when taken as it was apparent the applicant would be eligible within 90 days (See Sec. B-014.45) the underpayment is to be adjusted provided:

- (1) The applicant or recipient met his responsibility for reporting promptly all facts required of him pursuant to W&IC Section 103.3, Item b; and
- (2) The retroactive aid can be authorized before the end of the eighth month following that in which the discontinuance or denial action occurred.

(The authorization is to be in the amount to which the person was eligible and for the period during which he would have received aid if such aid had been granted or continued instead of denied or discontinued.)

c. Incorrect Beginning Date

If aid is not authorized in accord with the W&IC and regulations governing the beginning date and underpayment occurs on a new case, a restoration, an inter-county transfer, or a transfer between ANB-APSB, and OAS such underpayment is to be adjusted provided the amount due can be authorized before the end of the eighth month following the month in which aid was to have begun.

ADJUSTMENT BY THE APPEAL PROCESS

Underpayment (regardless of cause) shall be adjusted by authorization of aid in the amount and for the period ordered by the SSWB or agreed to by the SDSW (see Secs. 055.3 and 055.4).

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B-310.15

DECREASING DEPENDENCY

Regulations

B-310.15 COUNTY RESPONSIBILITY FOR SERVICES - GENERAL - ANB-APSB

B-310.15

Specifically the county welfare department is responsible for:

1. Identifying and evaluating problems or needs in addition to those which can be met by a money payment through the grant. This responsibility covers problems of health, education, living arrangements, social isolation, personal adjustments to blindness, economic rehabilitation and self-care.
2. Developing a service plan for meeting the problems identified and evaluated, by
 - a. Providing such services as the individual may need and the county is able to render, through direct service, an organized special resource and referral to other resources; and
 - b. Where referral is made, assisting individuals to use these other resources to their best advantage.
3. Community planning activity including:
 - a. Identifying the need for resources in the community to meet problems found among blind persons;
 - b. Making needs of applicants and recipients for community resources known to the community;
 - c. Stimulating community action which affects the Social Welfare Programs for the Blind either directly or indirectly or meets the needs of individual applicants and recipients;
 - d. Participating in joint planning with other agencies and groups in developing needed resources; and
 - e. Developing working relationships with other agencies providing needed services to assure the maximum availability of these services to applicants and recipients.

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CONTINUATION SHEET
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The following number changes are to be effective October 1, 1959:

B-205.12 changed to B-205.14
B-205.14 changed to B-205.15
B-225.1 changed to B-225.6

The following sections are to be repealed effective September 19, 1959:

B-207.4 Time Limit for Payments on Debts - ANB-APSB
B-227.52 Underpayment Due to Erroneous Denial Action -ANB-APSB

The following section is to be repealed effective October 1, 1959:

B-205.20 Choice of Practitioner - ANB-APSB

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FACE SHEET
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WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

RECEIVED FOR FILING

AUG 18 1959

Division of Administrative Procedure

ENDORSED

APPROVED FOR FILING
(GOV. CODE 11380.2)

AUG 18 1959

Division of Administrative Procedure

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Copy below is hereby certified to be a true and correct copy of regulations adopted, or amended, or an order of repeal by:

STATE DEPARTMENT OF SOCIAL WELFARE

(Agency)

Dated: August 18, 1959

By:

Director

(Title)

FILED

In the office of the Secretary of State
of the State of California

AUG 18 1959

At 3:45 o'clock P.M.

FRANK M. JORDAN, Secretary of State

Assistant Secretary of State

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Regulations

D-125.20 DETERMINATION OF ELIGIBILITY OF ALIENS RESIDENT SINCE 1/1/32 D-125.20

The applicant's sworn statement on Form DA 200c establishes his initial eligibility, in the absence of information to the contrary, on the facts that he has not been convicted of an overt act against the United States Government and that he is proceeding diligently within the limits of his ability to become a citizen.

The fact that the applicant has lived in the United States continuously since 1/1/32 must be established by evidence. A statement from the Department of Immigration and Naturalization that the applicant entered the United States on a specified date and, to their knowledge, has not left the country is sufficient evidence (in the absence of information to the contrary) to establish continued presence in the United States.

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These Regulations are designated to become effective September 19, 1959

CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

The following number change is to be effective September 19, 1959:

D-122 changed to D-125.20

The following section is to be repealed effective September 19, 1959:

D-227.52 Underpayment Due to Erroneous Denial Action

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CONTINUATION SHEET
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WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

Regulations RECORDS, FORMS AND CONTROLS D-021

D-021 COUNTY RESPONSIBILITY FOR CASE RECORDS D-021

The county is responsible for maintaining a case record for each applicant and/or recipient which identifies the individual, his address, and household composition, and which shows:

1. The pertinent information obtained during the investigation conducted in accord with the requirements of Secs. D-012.40 and D-012.50, and the sources from which it was secured.
2. That evidence was evaluated as required in Sec. D-012.60.
3. The needs of the individual and the money amounts allowed under the Table of Allowances, and the needs of the individual which cannot be met through the grant. (See Sec. D-201).
4. That income and resources were explored as required by Sec. D-212, and that the amount was computed as specified in Sec. D-212.30, et seq.
5. The original or a copy of all forms completed during the original and subsequent investigations, and relating to any transfer of responsibility for payment of aid between counties except (1) when the date DA 239 was mailed is recorded elsewhere, or (2) when the record contains a cross-reference to Form ABD 236 A or B; requests for restoration as defined in Sec. D-010.14, correspondence to and from the county pertinent to the individual's eligibility, his grant, and/or activities toward meeting economic and social needs.
6. The computation of the amount of any overpayment, and the amount of repayment due, if any; a copy of any demands for repayment; the facts regarding the determination of the debtor's ability to repay and collection activity as required by Sec. F-420, et seq., unless this information is recorded centrally elsewhere.
7. A narrative or text containing relevant data (including dates) secured during client or collateral contacts, which does not appear elsewhere in the case record (or which is necessary to augment or reconcile data or information recorded in forms or correspondence); entries to reflect the client's reaction to or understanding of the county's interpretation of his rights and responsibilities.
8. A record of facts reported by the applicant or recipient as required by W&IC 103.3(b).
9. The basis for the decision that the individual met, or did not meet, the conditions of eligibility.
10. The county action granting, denying, changing, suspending, cancelling or discontinuing aid.
11. For a recipient in a public medical institution:
 - (a) Whether or not he requires assistance in making full use of the personal and incidental needs allowance
and
 - (b) The basis for the determination
 - (c) If assistance is required, the relative, agency or other person currently assisting him
and
 - (d) The plan arrived at with the recipient and worker for the use of the recipient's allowance for personal and incidental needs, and any action taken by the worker, agency or person assisting in the plan. (See Handbook Sec. B-225.)

CALIFORNIA-SDSW-MANUAL-ATD

CONTINUATION SHEET
**FILING ADMINISTRATIVE REGULATIONS
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Regulations

D-022.72 RETENTION SCHEDULE

D-022.72

With the exception of the items listed here with specific retention periods, all case record material is to be retained.

The following items may be removed from the case record and destroyed at the expiration of the time periods stated.

1. Form DA 158 (or county substitute) - 4 years
2. Form ABCD 215 - 3 years
3. Forms DA 239 and ABCD 239 (or county substitute form) - No retention required.
4. Form 278 (or county substitute) - 4 years

Form 278M (or county substitute form) - until written notification is received from SDSW that these forms may be destroyed.

5. Warrant hold and release notices - 2 years
6. Correspondence (except supporting documents) - 3 years

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CONTINUATION SHEET
**FILING ADMINISTRATIVE REGULATIONS
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Regulations

D-025 REQUIRED FORMS FOR WHICH SUBSTITUTE MAY BE USED

D-025

The following forms are required to be completed for the purposes indicated in the instructions for their use, except that the county may use a substitute form which provides the same information.

DA 4	Transmittal of ATD Reports
DA 158	Aid to the Needy Disabled - Budget Work Sheet (See Sec. D-201)
	If a substitute is used by the county for the DA 158, the county is required to submit to SDSW one copy of SDSW Form DA 158 on all approved ATD applications.
DA 158V	Budget Work Sheet for Public Medical Institution cases
ABD 228	Authorization for Financial Investigation (See Sec. D-012.40)
DA 206	Recipient's Affirmation of Eligibility for Aid to the Needy Disabled (See Secs. D-015.20 and D-015.30)
DA 239	Notice of Action - Aid to the Needy Disabled (See Sec. D-014.70)
DA 239 C	Important Notice to all Recipients of Aid to the Needy Disabled
ABCD 239	Notice of Action
ABD 278L*	List of Authorizations to Start, Change, Stop or Deny Aid Payments. (See Sec. D-221)
ABD 278M*	Authorization to Start, Change or Stop Aid Payments (Action Card)

* Use of substitute Forms ABD 278L and/or ABD 278M require prior SDSW approval.

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CONTINUATION SHEET
FILING ADMINISTRATIVE REGULATIONS
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Regulations

D-140.10 DEFINITIONS

D-140.10

An Institution is a public or private facility which provides shelter and care, treatment of physical or mental illness, custody (nonmedical) or restraint (penal or correctional). They may be hospitals, nursing homes, board and care homes, prisons or other correctional facilities.

A Public Institution is one which is managed wholly or partially by a unit of federal, state or local government or is maintained from public funds.

A Public Medical Institution is a) any county, city or district hospital, or unit thereof, which is licensed under H&SC 1422 by the California Department of Public Health; b) a medical unit of the Veteran's Home of California; or c) a medical unit of a federal institution.

A Private Institution is a commercial, nonprofit, fraternal or benevolent facility managed and controlled by an individual, association or corporation.

D-140.20 ELIGIBILITY IN PUBLIC OR PRIVATE INSTITUTIONS

D-140.20

If otherwise eligible, a person may receive aid while a patient in a public or private institution with the following exceptions:

Exceptions:

1. A patient in an institution (public or private) for tuberculosis or mental illness;
2. A patient in a medical institution (public or private) as a result of a diagnosis of tuberculosis or psychosis;
3. An inmate of a public custodial (nonmedical), penal, or correctional institution. (If such institution were private, eligibility could be established.)

Patients in public medical institutions beyond a temporary period receive aid in accord with Sec. D-225, Vendor Payments to Public Medical Institutions. (Also see D-201.05, Determination of Need - Persons in Institutions.)

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CONTINUATION SHEET
FILING ADMINISTRATIVE REGULATIONS
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(Pursuant to Government Code Section 11380.1)

Regulations

D-202 ALLOWABLE NEEDS COMMON TO ALL RECIPIENTS

D-202

The following allowable items of need are considered common to all recipients and are to be provided unless otherwise specified:

ATD - Standard of Assistance

Basic Need	Noninstitutional Table of Allowances (Living alone or sharing a household)
Food	\$29.00
Housing and Utilities "as paid" to a maximum of \$30	*
Household maintenance	6.00
Medicine chest supplies	1.50
Telephone service	1.50
Clothing	8.00
Personal care and incidentals	7.50
Education and recreation	7.50
Services and equipment related to disability	15.00
	<u> </u>
	\$76.00

*The total allowance is considered to be \$76, plus cost of housing and utilities to a maximum of \$30

Basic Need	Institutional Table of Allowances* (Board and care basis)
Board and care	\$90.00 maximum allowable
Personal and incidental needs allowance	16.00
	<u> </u>
	\$106.00

* For persons in public medical institutions beyond a temporary period, part or all of the grant is paid directly to the institution as a vendor payment. (See Section D-225.)

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CONTINUATION SHEET
**FOR FILING ADMINISTRATIVE REGULATIONS
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 (Pursuant to Government Code Section 11380.1)

Regulations

D-205 DETERMINATION OF NEED FOR MEDICAL CARE - GENERAL D-205

Definition

In ATD, medical care includes only those services and items that are required to achieve functional improvement. (See Sec. MC-031.5)

D-205.10 METHODS OF PROVIDING MEDICAL CARE D-205.10

Needed medical care within the limitations described above is provided through sources specified by Sections D-205.11 and D-205.13.

D-205.11 USE OF COMMUNITY RESOURCES D-205.11

Community resources which are available to an applicant or recipient are to be utilized in preference to payment from the Medical Care Fund.

D-205.13 USE OF MEDICAL CARE FUND (See Appendix - Medical Care) D-205.13

The cost of medical care of a type included within the scope of the Medical Care Fund (See MC-031.5) will be paid from the fund on behalf of an otherwise eligible recipient when:

- a. Payment of aid is withheld or suspended because of a question concerning the amount of the recipient's grant (See D-226.10 and D-226.12), or
- b. Authorization of aid is decreased to zero for one or two months as an adjustment for an overpayment as provided in Sec. D-227.10.

D-205.20 CHOICE OF PRACTITIONER D-205.20

The county may designate a physician, hospital, clinic, group of physicians and other ancillary personnel to evaluate recipients for functional improvement services and to provide needed services.

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CONTINUATION SHEET
**FILING ADMINISTRATIVE REGULATIONS
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Regulations

D-201.05 DETERMINATION OF NEED - PERSONS IN INSTITUTION

D-201.05

The county is responsible for determining whether or not the recipient lives in an institution and for computing his needs accordingly. When a recipient is hospitalized for a temporary period, it is not considered that he "lives" in an institution. He may receive up to two warrants with which to meet his on-going needs outside the institution, provided he remains eligible.

Starting with the third month following admission to a public medical institution, part or all of the grant is retained for payment to the institution in accord with Sec. D-225. The recipient is entitled to an allowance for his personal and incidental needs, either through retaining his income or by receiving a grant for this purpose.

D-225 VENDOR PAYMENTS TO PUBLIC MEDICAL INSTITUTIONS

D-225

D-225.1 PATIENT ADMITTED TO PUBLIC MEDICAL INSTITUTION WHILE A RECIPIENT

D-225.1

When a recipient is a patient in a public medical institution, as defined in Section D-140.10, the full amount of the grant is paid directly to him for the first two calendar months following his admittance to the institution. If he remains a patient in the public medical institution beyond two calendar months, part or all of the grant is retained by the county for payment to the institution, starting with the third month following his admittance.

Exception: If the recipient is a patient in a public medical institution outside the State of California, the full grant is paid to him even though he remains in the institution for more than two calendar months.

D-225.2 AID GRANTED OR RESTORED TO A PATIENT IN A PUBLIC MEDICAL INSTITUTION D-225.2

When aid is granted or restored to a patient in a public medical institution and it appears that he will remain in such institution, part or all of the grant is retained for payment to the institution, starting with the effective date of the grant.

Exception: If the effective date of the grant precedes the date of admittance to the institution, payment is made in the same manner as if he had been a recipient at the time of admittance.
 (See I. above.)

D-225.3 COMPUTATION AND DISTRIBUTION OF PAYMENT BETWEEN THE RECIPIENT AND INSTITUTION D-225.3

The total aid payment to be made to and/or on behalf of the recipient who is a patient in a public medical institution is determined in accord with Section D-221, Amount of Aid Payment. Income received by the public medical institution on behalf of the recipient, but not available to the recipient for his personal and incidental needs, is considered in determining the amount of the aid payment in accord with Section D-221, but is disregarded in determining distribution of the payment between the recipient and the institution.

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**FILING ADMINISTRATIVE REGULATIONS
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Regulations

D-225.3 (Continued)

D-225.3

When all or a part of the aid payment is to be paid to the institution, the distribution is authorized as follows:

1. Recipient has no income

A direct payment of \$16 is made to the recipient for his personal and incidental needs. The balance of the grant is paid to the public medical institution.

2. Recipient has income less than \$16

A direct payment of the difference between his income and \$16 is made to the recipient. The balance of the grant is paid to the institution.

3. Recipient has income of \$16 or more

The entire grant is paid to the public medical institution.

D-225.4 RECIPIENT IS DISCHARGED OR ELIGIBILITY STATUS CHANGES WHILE IN THE INSTITUTION D-225.4

If the recipient continues to be eligible to receive aid, he receives the full grant for the month in which he is discharged or otherwise leaves the public medical institution; i.e., no portion of the grant is paid to the institution.

If the recipient becomes ineligible to continue receiving aid for any reason during a month while he is a patient in the public medical institution, payment is made to the institution for the full month. Such situations include, but are not limited to:

- A. The recipient is moved to an ineligible unit of the institution, i.e., a custodial ward, a unit established for care of tuberculosis or mental patients.
- B. The recipient's continued care in the institution is the result of a diagnosis of tuberculosis or psychosis.
- C. The recipient dies.

Care in the public medical institution is considered continuous when, within ten days of leaving the institution, the recipient is re-admitted for the same ailment; i.e., payment starting with the month following readmittance is made in the same manner as if there had been no discharge or interruption in the care in the institution. (See Sec. D-141.40, Evidence of Eligibility in a Public Medical Institution.)

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D-011.20

DETERMINATION OF ELIGIBILITY

Regulations

D-011.20 WHEN APPLICATION TO BE TAKEN

D-011.20

The application, Form DA 200, shall be signed and acknowledged on all requests for aid at the time the applicant first makes known his need, unless this is reported by telephone or letter. The only exceptions to the requirement that an application be signed when request is made are:

1. When the applicant recognizes that he is ineligible and states that he does not wish to continue with the application
2. When an application or request for restoration has been denied and corrective action is to be taken. (Aid is then granted on the same application or request for restoration which was previously denied. See Sec. D-227.60, Items 1 and 2 regarding denial actions subject to correction.)
3. When restoration is requested from the same county within one year from the effective date of discontinuance of ATD
4. When aid is granted on appeal to the SDSW
5. If the SDSW finds, upon review of subsequent medical and social data reports, that an individual whose aid had been denied or discontinued within a period of less than twelve months, because he was not found to be permanently impaired and totally disabled, is eligible as to permanent impairment and total disability.
6. When aid is granted on an intercounty transfer (see Sec. D-016).

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CALIFORNIA-SDSW-MANUAL- ATD

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CONTINUATION SHEET
**FILING ADMINISTRATIVE REGULATIONS
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 (Pursuant to Government Code Section 11380.1)

D-223

AID PAYMENTS

Regulations

D-223

BEGINNING DATE OF AID

D-223

Subject to the provisions of W&IC 104.1, 4181.5, and 4182, the beginning date of aid is determined as follows:

1. When aid is authorized in the same month in which the application is signed or restoration requested, aid is paid from the date of signing of the application or requesting restoration.

Exception:

If the recipient transfers from one county to another, payment of aid must be continuous and when necessary to make payment continuous, the beginning date of aid in the second county may antedate the signing of the application in the second county.

2. When aid is authorized in a month subsequent to that in which the application is signed or restoration requested, aid is paid from the first day of the month in which authorization action is taken.
3. Aid which is authorized on an application which was previously denied as provided in Sec. D-227.60 is paid from the date it would have been paid had there been no denial action.
4. If an application was denied following determination by SDSW that the applicant did not meet the disability requirements and subsequent medical, psychological, psychiatric and/or social data report results in a reversal of this decision, SDSW shall specify the date on which disability shall be considered to have existed for purposes of eligibility and aid is paid in relation to that date. (See Sec. D-227.60, Item 2,b.)

D-224

INITIAL PAYMENTS

D-224

An initial payment is the first payment made on new applications and restorations. (See Secs. D-014.10) An initial payment may be withheld (see Sec. D-226.10) but is to be canceled or delivered before the end of the month for which it was authorized. An initial payment is not to be suspended. (See Sec. D-226.12, Suspension of Aid.)

An initial payment is to be made within the month for which aid is granted or restored, or not later in the following month than the time such payments are normally issued under the county's customary fiscal procedure. An initial payment includes aid for prior months if retroactive aid is authorized because:

1. Aid was granted on appeal to the SSWB;
2. The SDSW concurs in a county recommendation that retroactive aid be paid to adjust an appeal (see Sec. 055.3, Stipulated Appeals);
3. An application or request for restoration for aid has been denied and corrective action is being taken (see Sec. D-223, Beginning Date of Aid and D-227.60, Adjustment of Underpayment by Authorization of Retroactive Aid.)
4. SDSW reverses an earlier determination of disability upon receiving additional information and specifies an earlier date on which disability is considered to have existed for purposes of eligibility.

CALIFORNIA-RENTAL-MANUAL-ATD

CONTINUATION SHEET
**FILING ADMINISTRATIVE REGULATIONS
 WITH THE SECRETARY OF STATE**
 (Pursuant to Government Code Section 11380.1)

Regulations

AID PAYMENTS

D-227.60

D-227.60 ADJUSTMENT OF UNDERPAYMENT BY AUTHORIZATION OF RETROACTIVE AID

D-227.60

Definition

Retroactive aid is aid authorized in a subsequent month for some preceding month or months.

Adjustment by County Administrative Action

Underpayment is adjusted by administrative action authorizing payment of retroactive aid under the circumstances prescribed below and within the time limits specified.

1. Underpayment resulting from an administrative error or inadvertence (see Sec. D-227.51)

Such underpayment (including underpayment resulting from a denial or discontinuance due to administrative error or inadvertence) is to be adjusted as provided in W&IC Sec. 103.3, Item (f).

2. Underpayment resulting from other causes

Underpayment resulting from causes other than "administrative error or inadvertence" or from "erroneous denial" is to be adjusted in accord with whichever of the following circumstances is appropriate:

- a. Recipient Eligible to a Larger Grant than that Authorized

When aid is paid in the amount authorized but it is later determined that the recipient was eligible for a greater amount (as determined in accord with Section D-221), the underpayment is to be adjusted provided the additional amount due can be authorized before the end of the **eighth** month following the month for which the recipient was underpaid.

Medical need which can be included in the grant only as a retroactive payment is to be adjusted (subject to the **eight-month** limitation) regardless of the amount of the underpayment. Underpayment of \$2 or less for a particular month resulting from a cause other than such medical need is adjusted only when a necessary increase of \$2 or less in the continuing grant (see Sec. D-226, Changes in Amount of Payment) was not made effective until after the second month following that in which the changed circumstances were reported. Payment of retroactive aid in such circumstances shall begin with such second month.

(Continued)

CALIFORNIA-SDSW-MANUAL-ATD

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D-227.60

AID PAYMENTS

Regulations

D-227.60 (Continued)

D-227.60

b. Aid Denied or Discontinued to an Eligible Person

When, within six months after date of applicant's or recipient's notification of a denial or discontinuance, the county obtains additional information which indicates eligibility existed for the denied or discontinued payments, the underpayment is to be adjusted provided:

- (1) The applicant or recipient met his responsibility for reporting promptly all facts required of him pursuant to W&IC Sec. 103.3, Item (b) and
- (2) The retroactive aid can be authorized before the end of the **eighth** month following that in which the discontinuance or denial action occurred.

(The authorization is to be in the amount to which the person was eligible and for the period during which he would have received aid if such aid had been granted or continued instead of denied or discontinued.)

c. Incorrect Beginning Date

When aid is not authorized in accord with the code and regulations governing the beginning date, and underpayment occurs on a new case, a restoration or an intercounty transfer, such underpayment is to be adjusted provided the amount due can be authorized before the end of the **eighth** month following the month in which aid was to have begun.

Adjustment by the Appeal Process

Underpayment (regardless of cause) shall be adjusted by authorization of aid in the amount and for the period ordered by the SSWB or agreed to by the SDSW (see Secs. 055.3 and 055.4).

CALIFORNIA-SDSW-MANUAL-ATD

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FACE SHEET
FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

RECEIVED FOR FILING

AUG 18 1959

Division of Administrative Procedure

ENDORSED

APPROVED FOR FILING
(GOV. CODE 11380.1)

AUG 18 1959

Division of Administrative Procedure

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Copy below is hereby certified to be a true and correct copy of regulations adopted, or amended, or an order of repeal by:

STATE DEPARTMENT OF SOCIAL WELFARE
(Agency)

Dated: August 17, 1959

By: *[Signature]*

Director
(Title)

FILED

In the office of the Secretary of State
of the State of California

AUG 18 1959

At 3:45 o'clock p.m.

FRANK M. JORDAN, Secretary of State

By: *[Signature]*
Assistant Secretary of State

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BH-105.10 INTERVIEWS

BH-105.10

Each study shall include a sufficient number of interviews with the applicants to determine their ability to meet the needs of foster children or aged guests.

At some appropriate point, the standards shall be reviewed with the applicant.

When issuance of a license is anticipated, the requirements relating to the maintenance of a register and strict adherence to the terms of the license shall be explained.

Applicants eligible to license shall be advised that forms (BHA 50 - Identification and Emergency Information - Residents - Homes for Aged, BHC 50 - Boarding Home Register - Child Placed by Agency) are available for use in maintaining the required register, and shall be provided with a supply of appropriate forms.

BH-122.71 BEDROOMS

BH-122.71

Bedrooms shall provide privacy, be adequately ventilated and located within call of an adult.

1. Size

A bedroom occupied by one child shall have 630 cubic feet of air space and 16 square feet of window space; a bedroom for two shall have 810 cubic feet of air space and window space equal to one-eighth of the floor area, but not less than 16 square feet. In a bedroom for three or more, there shall be an additional 500 cubic feet per person.

2. Sharing

Children of opposite sex over five years of age shall not share a bedroom, and children over one year of age shall not sleep in the same room with an adult.

These regulations are designated to become effective September 19, 1959

CONTINUATION SHEET
OR FILING ADMINISTRATIVE REGULATIONS
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BH-105.41 VERIFICATION OF FREEDOM FROM TUBERCULOSIS - BHC

BH-105.41

Unless all members of the household are exempt from these requirements because of their religious beliefs, each study shall include:

1. A determination that all necessary reports on intradermal tuberculin tests or chest X-rays have been secured within the last twelve months. (See Handbook Sec. BH-120.24)
2. An examination of these reports to insure that freedom from active tuberculosis has been certified.

BH-105.83 TERMS OF THE LICENSE

BH-105.83

1. General

The license shall specify the maximum number of foster children or aged guests to receive care at any one time.

When continued care of a particular child or aged person requires special permission, the license shall specify the name of each person whose care is so authorized.

Any other limitations indicated by the study shall be written on the license or included in the transmittal letter.

2. Boarding Homes for Aged Persons

Unless the care of nonambulatory aged persons has been approved by fire safety officials, each BHA license shall state "Ambulatory aged only." When such approval has been given, the license must specify the number of nonambulatory persons included in the licensed capacity. (See Sec. BH-105.51.)

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Regulations

BH-105.83 (Continued)

BH-105.83

3. Boarding Homes for Children

The license issued to a foster home for children shall specify (1) the age range and sex of the foster children and (2) the type of care authorized (i.e., "For day care only;" "For 24-hour care only" or "For parent-child care only").

When foster parents and/or other members of the household have claimed exemption from the requirements relating to intradermal tuberculin tests and chest X-rays on the basis of their religious faith, the license shall be limited to the care of children of the same faith. (See W&IC 1632)

For foster homes which operate a summer program for a larger number of children, the license shall clearly state both the number of children permitted for year-round care and the number of children permitted for summer care. If the summer capacity has not been determined at the time license is issued for year-round care, a new license shall be issued when the summer capacity is determined. This license shall indicate the number permitted for year-round care, as well as the number for whom summer care is authorized.

BH-107 SUPERVISION OF LICENSED HOMES - AGED AND CHILDREN

BH-107

At least two supervisory visits shall be made before the expiration of the current license. One of the required visits may be the visit made as part of the renewal study. See Sec. BH-108.21. (W&IC 2301 requires a minimum of two visits each year.)

BH-107.31 CHANGE IN TYPE OF CARE

BH-107.31

When a licensee requests a change in the type of child care (i.e., day care, parent-child care or 24-hour care) or a change from child care to the care of aged persons, or vice versa, the need to file a new application shall be explained.

CONTINUATION SHEET
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Regulations

BH-108.10 AGENCY RESPONSIBILITY FOR RENEWAL

BH-108.10

The accredited agency shall maintain a control file in order that each case will automatically come to attention 90 days before the expiration of the license.

When eligibility to a renewal license is doubtful, a visit to the home shall be made at least 60 days prior to the expiration of license.

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(Pursuant to Government Code Section 11380.1)

BH-108.10 (Continued)

BH-108.10

If conditions found during this visit seem to warrant the denial of a renewal application, this fact shall be explained and the licensee helped to develop plans for termination of operation before the expiration of his current license. If the licensee wishes to exercise his right to file a renewal application, however, the appropriate application form (BHC 11 or BHA 11.1) shall be provided and plans for the renewal study made. (See Sec. BH-108.21.)

Other licensees shall be requested to file a renewal application at least 60 days prior to the expiration of license.

BH-108.20 STUDY OF RENEWAL APPLICATION

BH-108.20

On receipt of a renewal application, a renewal study shall be completed as soon as administratively possible.

When there is substantial doubt that a boarding home for aged persons is eligible for license, the renewal study shall be completed at least 30 days prior to the expiration of license. (See Sec. BH-108.26.)

BH-108.21 CONTENT OF RENEWAL STUDY

BH-108.21

The renewal study shall include:

1. At least one visit to the applicants' home.
2. A review of the register (Form BHA 50, BHC 50 or BHC 50.1) giving information about the children or aged persons under care during the past year to determine compliance with the requirements concerning (a) the maintenance of a register and (b) adherence to the limitations of the last license. (See Sec. BH-124-126.)
3. A review of the tuberculin test and/or chest X-ray reports on file in the home to determine whether all necessary reports have been obtained during the last twelve months. (See Handbook Sec. BH-120.24)
4. Any clearances required to determine continued conformity with state laws and regulations relating to housing, fire safety and sanitation. (See Sec. BH-107.35.)
5. Any necessary verification that other standards are currently met.
6. Evaluation of the home in terms of service to the children or aged guests who have been placed there.

This evaluation shall be based on information gathered by the licensing agency during supervision of the home in the past year, as well as on impressions received during the renewal visit. Whenever readily available, it shall also include information from agencies or individuals who have used the home during the past year.

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**FILING ADMINISTRATIVE REGULATIONS
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 (Pursuant to Government Code Section 11380.1)

Regulations

BH-108.21 (Continued)

BH-108.21

7. Recording of the evaluation, as well as the information on which it is based.

BH-108.25 ISSUANCE OF RENEWAL LICENSE

BH-108.25

When the requirements for license are met, a renewal license shall be issued in the manner described for an initial license. (See Secs. BH-105.80 through BH-105.83.)

A renewal license shall be issued to an operator of a boarding home for aged persons on or before the date on which the last license expires unless:

1. A renewal application (BHA 11.1) was not filed ten days before the expiration of the last license (W&IC 2303 and 2304) or
2. A letter notifying the operator of the denial of his application was sent 30 days prior to the expiration of license (See Sec. BH-108.26, Item 2.)

If necessary clearances are received before the last license expires, a renewal license shall be issued to an otherwise eligible operator of a boarding home for aged persons, even though a letter of denial was previously sent.

BH-108.26 MODIFICATION OR DENIAL OF RENEWAL LICENSE

BH-108.26

1. Modification of License

When a renewal application requests a license with terms identical with those of the last license issued and decision is made to issue a more restrictive license (e.g., reduced capacity, care of named persons only, further limitations in the age range of children, etc.), the reasons for this decision shall be carefully discussed with the licensee. If the licensee indicates that he is dissatisfied with this decision, the right of appeal shall be explained.

When the license is issued, it shall be sent to the licensee with a registered letter explaining the reasons for modification in the terms of the license, the right of appeal from a change in the terms of the license, and the time limit for filing an appeal (30 days).

If the decision involves a boarding home for aged persons, this letter must be sent at least 30 days prior to the expiration of the current license. (See W&IC 2303)

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Regulations

BH-108.26 MODIFICATION OR DENIAL OF RENEWAL LICENSE

BH-108.26

2. Basis for Denial

A renewal license shall be denied when any of the following conditions are found during a renewal study:

- a. Evidence of mistreatment or neglect of children or aged persons (either physical or emotional) which the licensee is unable or unwilling to correct.
- b. Serious life or health hazard in the home which the licensee has been instructed to correct and which he refused, failed or found it impossible to correct within a reasonable period of time.
- c. Persistent violation of the terms of the license.
- d. Other serious violations of the standards.

When it is necessary to recommend denial of a renewal application, all procedures required in the denial of an initial application shall be completed. In addition, the letter of notification shall inform the applicant of his right of appeal and of the 30 day time limit for filing an appeal.

Any letter notifying the operator of a boarding home for aged persons that his renewal application will be denied must be mailed at least 30 days prior to the expiration of his current license. (See W&IC 2303)

3. Right of Appeal

On receipt of an appeal from a denial or modification of a renewal license, the accredited agency shall immediately notify the Area Office of the SDSW in writing, giving the name and address of the licensee and all pertinent information including licensing history, the basis for denial or modification of the license and a summary of the agency's efforts to correct the situation.

BH-108.28 EXPIRATION WITHOUT REAPPLICATION

BH-108.28

If application for a renewal license is not received prior to expiration of the previous license, the case shall not be closed until it is known that there are no children or aged persons living in the home.

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Regulations

BH-108.28 (Continued)

BH-108.28

If foster children or aged guests are in the home, the provisions of the law relating to operation without a license shall be called to the attention of the former licensee and opportunity given to file an application. If an application is not filed or care discontinued, the situation shall be referred to the district attorney for action. (See Sec. BH-106.)

If a former licensee wishes to file an application, he shall be advised of the need to file a new application (BHA 10 or BHC 10.1) and provided with the appropriate form. (By law, the right to file a renewal application is terminated ten days prior to the expiration of the last license. (See W&IC 1624 and 2304))

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Regulations

BH-124.33 MENTALLY RETARDED CHILDREN

BH-124.33

Foster homes shall not accept children who are mentally retarded unless the licensing agency gives written permission for the care of a particular child. Such permission will only be given when all of the following conditions are met:

1. The foster home can meet the individual needs of this child.
2. His presence will have no adverse effect on any other children in the home.
3. There is no substantial difference between the kind and amount of care needed by the mentally retarded child, and that needed by children of normal mentality.
4. The foster parents intend to care for children of normal mentality when this child is removed from their home.

Foster homes which plan to care for mentally retarded children only are subject to license by the State Department of Mental Hygiene.

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Regulations

AD-119.1 COUNTY ADOPTION AGENCY AGREEMENTS - MATERNITY CARE PROGRAM AD-119.1

If a county adoption agency makes a plan for maternity care for the unmarried mother, it shall enter into an agreement with a licensed physician and surgeon, a licensed private hospital, or a hospital operated by the Regents of the University of California or a combination of these for the care of the expectant unmarried mother who is financially unable to provide for her own care.

AD-119.2 TO WHOM PAYMENT IS MADE

AD-119.2

Payment for the unmarried mother's maternity care shall be made directly to the physician, private hospital, hospital operated by the Regents of the University of California, clinic, or medical facility. (See Fiscal Manual Sec. F-925.)

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Regulations

CI-148 PERSONNEL PRACTICES

CI-148

Personnel practices shall be designed to attract and keep adequate staff.

Confidential records shall be kept of all personnel employed.

Child care staff shall have at least one full day off and be able to leave the institution each week.

Workmen's compensation insurance shall be carried.

A physical examination shall be given each employee before he begins work. This examination must include an intradermal tuberculin test and if this test is positive, a chest X-ray. (By law, the institution must also have on file, reports showing that each employee has had the required test or X-ray during the last twelve months, and is free from active tuberculosis. See Section 1632 of the W&I Code.)

Employees with responsibility for the preparation or serving of food shall have daily health supervision and when symptoms of illness appear, they shall be excluded from work until recovery, or clearance from a physician or staff nurse.

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Regulations

DN-148.1 PERSONNEL PRACTICES - STAFF HEALTH

DN-148.1

A complete physical examination by a licensed physician shall be required of each staff member (including the director, teachers, parent participants, cooks et cetera) prior to beginning work.

This examination must include the verification of freedom from tuberculosis required by Section 1632 of the W&I Code. (By law, the nursery must also have on file, reports showing that each employee has had the required test or X-ray within the last twelve months, and is free from tuberculosis.)

The physician's report shall be in writing and shall be kept on file in the nursery.

Staff members shall not be allowed to come to work when ill with contagious diseases (such as colds) or with other illnesses which would affect their performance.

Members of the staff shall be referred to their physician for checkups when necessary.

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IV-250 PERSONNEL PRACTICE
 (Subsection 6 only)

IV-250

6. Physical ExaminationRules

Each staff member must be in good physical and mental health.

Policy must require that each prospective employee submit a satisfactory written report of a recent physical examination made by a licensed physician. To fulfill this requirement, the physician's statement must certify that the job applicant is physically able to perform the required duties and is free from venereal disease, tuberculosis, and all other communicable infections. All employees who are in contact with infants, or have responsibility for the preparation or serving of food must be required to have annual physical examinations.

To comply with W&IC Sec. 1632, policy must also require that each employee submit an annual certificate showing that he has had an approved intradermal tuberculin test, and that if positive, this test was followed by a chest X-ray. (By law, the maternity home must have on file, reports showing that employees have had the required test or X-ray within the last twelve months and are free from active tuberculosis.)

Policy must also require that the executive accept responsibility for insuring that no staff member comes to work when ill (either with contagious disease, such as colds, or with other illnesses which would affect their performance or the health of other persons), and that any employee showing symptoms of illness be excluded from work pending clearance from a physician or staff nurse.

Recommendations

The examining physician should be provided with information about the purpose of the potential employee's examination, and should be asked for an evaluation of the potential staff member's ability to perform the work he will be required to do. Similar information should be provided for the annual examination of an employee.

All employees should be required to have annual physical examinations.

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**FILING ADMINISTRATIVE REGULATIONS
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 (Pursuant to Government Code Section 11380.1)

W&IC 115, 116, 1510,
1557, 1560

J. M. WEDEMEYER
Director

EDMUND G. BROWN
Governor

State of California
DEPARTMENT OF SOCIAL WELFARE
 722 Capitol Avenue
 Sacramento 14

DEPARTMENT BULLETIN NO. 450-A (ANC)

TO: CHILDREN'S INSTITUTIONS
 MATERNITY HOMES

Subject: Applications for ANC Filed
 by Institutions

Effective September 19, 1959, Chapter 1788, Statutes of 1959 (Assembly Bill 1417) increases the maximum amount payable to an institution on behalf of a needy child under the provisions of W&I Code Section 1557 from \$24 to 67.5 percent of \$75 or \$50.63 a month.

1. The references in Department Bulletin No. 450 to the maximum amount payable are amended as follows:

Section III (page 3) Amount of State Funds Available Under The ANC Program.

If the contribution of a parent, or other income for the specific support of a child, is less than the institution's charge for care for the child, the institution may request state funds in the amount which is the difference between such income and the charge for care, except that state funds payable may not exceed 67.5 percent of \$75, or \$50.63 per month.

EXAMPLE 1: A child for whose support \$60 a month is being paid by his father is receiving care in an institution in which the charge for care is \$100 a month. The difference of \$40 between the charge for care and the support payment may be claimed by the institution.

EXAMPLE 2: The charge for care is \$90, and the child receives \$23 a month from a trust fund. Since the difference between the charge for care and the income is \$67, which exceeds the maximum state funds available, the full amount of state funds, \$50.63, may be claimed by the institution

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If eligibility is established, state funds are available from the date the application, Form CA 200A - Institution, is signed by the institution representative unless the institution indicates that the child's eligibility did not begin until a later specified date.

Section VII (page 6) Eligibility on First of Month
(amend first paragraph only)

For the child who is eligible on the first day of the month, the institution is entitled to receive state funds of \$50.63 (or, if the child has income, the amount determined under Section III) for the full month, even though the child's status may change at some time during that month. Therefore, if the child receiving ANC is in the institution (and eligible) on the first of the month, the institution may claim the full amount to which the child is eligible for the full month. Exception: If there is a transfer to another agency entitled to state funds, the total amount of state funds to both agencies may not exceed \$50.63 for the full month.

2. Procedure for Month of September 1959

Since the new maximum state payment becomes effective in the middle of the month (September 19) it will be necessary to compute the maximum amount payable for the month of September 1959 according to the proportionate number of days the child was eligible in the month in which the old and the new rates are effective, as follows:

<u>Period</u>	<u>Days</u>	<u>Maximum Allowed</u>	<u>Per Day</u>
September 1-18	18	\$14.40	\$.80
September 19-30	12	20.25	1.69
Total Maximum Amount		\$34.65	

EXAMPLE 1: The child is eligible for the entire month of September 1959. The charge for care is \$100. The child has no income. The institution may claim \$34.65, the maximum amount payable for September 1959.

EXAMPLE 2: The child's eligibility starts September 11, 1959. The institution's monthly charge for care is \$120; and for two-thirds of a month (September 11-30) it is \$80. Support payments from the absent parent are \$50 a month, leaving an unmet need of \$30 for September. The amount of state funds the institution may claim for September is \$23.85.
(September 11-18, or 8 days at 80¢ a day = \$3.60 plus \$20.25 for the period September 19-30).

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In the same example, if the September income had been \$60 with an unmet need of \$20 (\$80 charge for care less \$60 income), the institution would claim state reimbursement only in the amount of the unmet need, or \$20.

Very truly yours,

J. M. Wedemeyer
Director

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Regulations

C-011.40 WHEN APPLICATION TO BE TAKEN

C-011.40

The application, Form CA-200, Part I, shall be signed at the time the applicant first makes known the child's need. The applicant shall not be required to sign Part II until he is prepared to answer the specific questions. The only exceptions to the requirement that an application be signed when request is made are:

1. When the applicant recognizes that the child is ineligible and states that he does not wish to continue with the application.
2. When the application or request for restoration has been denied and corrective action is to be taken. (Aid is then granted on the same application or request for restoration which was previously denied. See Sec. C-227.60, Items 1 and 2 (b).)
3. When aid is requested for one or more children for whom aid was previously granted but whose aid has been discontinued for more than one year while other children in the family have continued to receive aid.
4. When aid is granted on appeal to the SDSW.
5. When aid is granted on an intercounty transfer.

If ANC is requested for a child for whom no application has previously been made, or whose application has been denied, although other members of the family group are receiving ANC or the county is processing an application for them, a new application shall be taken for the additional child at the time of request.

C-014.20 APPLICATION OR REQUEST FOR RESTORATION DENIED

C-014.20

County action shall be taken to deny aid to a child if:

1. Proof of ineligibility has been obtained.
2. All reasonable sources of proof of eligibility have been examined without establishing eligibility.
3. The applicant's whereabouts is unknown.
4. The applicant established residence in another state before the determination of eligibility was completed.
5. The parent refuses to accept reasonable employment or vocational rehabilitative training when either is appropriate. (See Sec. C-310.20.)
6. The parent who is available for employment and is physically and mentally able to work refuses to register for employment with the State Department of Employment. (See Sec. C-315.05.)

(Continued)

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Regulations

C-014.20 (Continued)

C-014.20

7. The parent refuses to give necessary information or refuses reasonable cooperation with law enforcement officers in securing support from an absent parent. (See Sec. C-156.)
8. The applicant does not complete Part 2 of the Application Form CA-200, after completing Part 1.
9. Ineligibility occurs after the legal beginning date of aid but before action has been taken to grant aid.

(See Sec. C-011.40, Item 2, and Sec. C-227.60, Items 1 and 2 (b) if denial action is taken in error.

C-223 BEGINNING DATE OF AID

C-223

Subject to the provisions of W&IC 104.1, 1550, and 1550.5, the beginning date of aid is determined as follows:

1. When aid is authorized in the same month in which the application is signed or restoration is requested, aid is paid from the date of signing of the application of request for restoration.
2. When aid is authorized in a month subsequent to that in which the application is signed or restoration requested, aid is paid from the first day of the month in which authorization action is taken. Exception: When authorization action is taken more than 45 days after the date of application or request for restoration, aid is paid from the first of the month in which authorizing action is taken or from the first of the month following the expiration of the 45-day period, whichever is earlier.

The 45-day period begins on the day following that on which an application is signed or restoration is requested. When the 45th calendar day falls on a Sunday or legal holiday, the following day is considered the last day of the 45-day period.

3. Aid which is authorized on an application which was previously denied as provided in Sec. C-227.60, is paid from the date it would have been paid had there been no denial action.
4. If eligibility is not established until a date subsequent to the date aid would begin under 1 or 2, aid is to begin on the date the child or family became eligible.

C-224 INITIAL PAYMENTS

C-224

An initial payment is:

- a. The first payment made on new applications and restorations (see Sec. C-014.10);

(Continued)

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Regulations

C-224 (Continued)

C-224

- b. The first payment for a child transferred from a boarding home to a family budget unit;
- c. The first payment for the addition of a child to a family budget unit already receiving ANC, or for the addition of a needy relative (if none has been included before) whether or not the actual payment is increased.

An initial payment may be withheld (see Sec. C-226.10) but is to be canceled or delivered before the end of the month for which it was authorized. An initial payment is not to be suspended. (See Sec. C-226.12)

An initial payment is to be made within the month for which aid is granted or restored, or not later in the following month that the time such payment are normally issued under the county's customary fiscal procedure. An initial payment includes aid for prior months if retroactive aid is authorized because:

1. Aid was granted on appeal to the SSWB;
2. The SDSW concurs in a county recommendation that retroactive aid be paid to adjust an appeal (see Sec. C-055.3, Stipulated Appeals);
3. An application for aid has been denied and corrective action is being taken (see Sec. C-223, Beginning Date of Aid, and C-227.60, Adjustment of Underpayment by Authorization of Retroactive Aid).
4. The investigation was not completed within 45 days after the application was signed or restoration requested. (See Appendix Fiscal Manual Sections, Sec. F-520.)

C-227.60 ADJUSTMENT OF UNDERPAYMENT BY AUTHORIZATION OF RETROACTIVE C-227.60 AID

Definition

Retroactive aid is aid authorized in a subsequent month for some preceding month or months.

Adjustment by County Administrative Action

Underpayment is adjusted by administrative action authorizing payment of retroactive aid under the circumstances prescribed below and within the time limits specified.

1. Underpayment resulting from an administrative error or inadvertence. (See Sec. C-227.51.)

Such underpayment (including underpayment resulting from a denial or discontinuance due to administrative error or inadvertence) is to be adjusted as provided in W&IC Section 103.3, Item f.

2. Underpayment resulting from other causes

Underpayment resulting from causes other than "administrative error or inadvertence" is to be adjusted in accord with whichever of the following circumstances is appropriate:

(Continued)

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Regulations

C-227.60 (Continued)

C-227.60

a. Recipient Eligible to a Larger Grant than that Authorized

When aid is paid in the amount authorized but it is later determined that the recipient was eligible for a greater amount (as determined in accord with Sec. C-221), the underpayment is to be adjusted, provided the additional amount due can be authorized before the end of the eighth month following the month for which the recipient was underpaid.

b. Aid Denied or Discontinued to an Eligible Person

When, within six months after date of applicant's or recipient's notification of a denial or discontinuance, the county obtains additional information which indicates eligibility existed for the denied or discontinued payments, the underpayment is to be adjusted provided:

- (1) The applicant or recipient met his responsibility for reporting promptly all facts required of him pursuant to W&IC Section 103.3, Item b; and
- (2) The retroactive aid can be authorized before the end of the eighth month following that in which the discontinuance or denial action occurred.

(The authorization is to be in the amount to which the person was eligible and for the period during which he would have received aid if such aid had been granted or continued instead of denied or discontinued.)

c. Incorrect Beginning Date

When aid is not authorized in accord with the code and regulations governing the beginning date, and underpayment occurs on a new case, a restoration, or an intercounty transfer, such underpayment is to be adjusted provided the amount due can be authorized before the end of the eighth month following the month in which aid was to have begun.

Adjustment by the Appeal Process

Underpayment (regardless of cause) shall be adjusted by authorization of aid in the amount and for the period ordered by the SSWB or agreed to by the SDSW (see Secs. 055.3 and 055.4).

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OR FILING ADMINISTRATIVE REGULA VS
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(Pursuant to Government Code Section 11380.1)

The following section is to be repealed effective September 19, 1959:

C-227.52 Underpayment Due to Erroneous
Denial Action

The following section is to be repealed effective October 1, 1959:

C-715 Submittal of Form CA-241, Budget
Work Sheet

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R FILING ADMINISTRATIVE REGULAT 5
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

Regulations

APPEALS

052

050

DEFINITIONS

050

An appeal is a request for a hearing by the SSWB concerning some action or inaction on a claim for Old Age Security, Aid to Needy Blind, Aid to Potentially Self-supporting Blind Residents, Aid to Needy Children, Medical Care under the foregoing programs, or Aid to Needy Disabled.

An appellant is an applicant, recipient, or the representative or heir of a deceased applicant or recipient who requests a SSWB hearing.

A referee is a hearing officer designated by the SSWB to hear the evidence and prepare proposed decisions on appeals.

A stipulated appeal is one in which the appellant, the county and the SDSW stipulate to the facts and recommendations and no decision by the SSWB is required.

052

RIGHT AND SCOPE OF APPEAL

052

A dissatisfied applicant or recipient may seek an adjustment by the county administering aid or may ask the SDSW to review his case. He is not required to exhaust county adjustment procedures before applying to the SDSW.

Requests to the SDSW for review may be either appeals for a hearing, or requests for assistance in obtaining an adjustment without a hearing. Having chosen either procedure the applicant or recipient may change to the other procedure subject to the statutory time limitation for filing appeals. Appeal hearings shall not be delayed or canceled without the consent of the appellant even though there is a possibility of adjustment without a hearing.

If an appellant dies after an appeal has been filed and before the Social Welfare Board has adopted a decision in the appeal, the appeal may be carried on behalf of his estate by the duly appointed legal representative of the estate, or by an heir of the deceased appellant if a legal representative has not been appointed by the court.

Appeals, wherein the issue is whether and in what amount the applicant or recipient was entitled to aid, and for which there has been no determination made by the SSWB, may be filed after the death of the applicant or recipient on behalf of his estate, by the duly appointed legal representative of the estate, or by an heir of the decedent if a legal representative has not been appointed by the court.

A vendor under the Medical Care Program is not an applicant or recipient and has no right of appeal to the SSWB.

(Continued)

CALIFORNIA-SDSW-MANUAL-

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(Pursuant to Government Code Section 11380.1)

052

APPEALS

Regulations

052 (Continued)

052

The county shall explain the right of appeal to every applicant at the time of application. Written notice of the right of appeal shall be included in every notification to the applicant or recipient of the granting, denial, increase, decrease, discontinuance, or suspension of aid or request for repayment.

The SDSW shall give each dissatisfied applicant, recipient or representative or heir of a deceased applicant or recipient information concerning informal review and the appeals process including a full explanation of (a) his right and responsibility in an appeal hearing, and (b) how to prepare for the hearing. He shall also be given reasonable assistance in preparation as he may require.

052.4 TIME LIMIT ON APPEALS

052.4

An appeal may not be filed more than six months after the order or action with which the applicant or recipient is dissatisfied. The date on which the appeal is first received in any office of the State Department of Social Welfare shall be considered the filing date.

The date of the order or action from which the appeal is taken shall be the date on which notice of such order or action was mailed to the appellant with the following exceptions:

1. In appeals for the return of erroneous repayments the date of collection or the date of the last installment payment is the determining date.
2. In appeals concerning the amount of the grant, the appeal must be filed within six months, but the period of review will extend back to the first day of the month in which the first day of the six month period occurred.
3. If the last day of the six month period falls on a Saturday, Sunday or holiday, the appeal may be filed on the next business day.

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FILING MANUAL

FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE

(Pursuant to Government Code Section 11380.1)

RECEIVED FOR FILING

AUG 18 1959

Division of Administrative Procedure

ENDORSED

APPROVED FOR FILING
(GOV. CODE 11380.2)

AUG 18 1959

Division of Administrative Procedure

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Copy below is hereby certified to be a true and correct copy of regulations adopted, or amended, or an order of repeal by:

State Department of Social Welfare

(Agency)

Dated: August 18, 1959

By:

Director

(Title)

FILED

In the office of the Secretary of State
of the State of California

AUG 18 1959

At 3:45 o'clock P.M.

FRANK M. JORDAN, Secretary of State

Assistant Secretary of State

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MC-052.05 BILLING DEADLINE

MC-052.05

Vendors should submit statements of services rendered by the 10th day of the month following each month of service. Statements received later than 6 months after the last day of the month in which the service is rendered shall not be paid.

With respect to services for which the department has executed an agreement with a fiscal agent, vendors shall submit statements of services rendered to such fiscal agent. Each statement shall carry the vendor's certification that the charge, within the maximum allowed under Chapter MC-04, constitutes the only charge made for the service rendered.

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These Regulations are designated to become effective September 19, 1959.

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(Pursuant to Government Code Section 11380.1)

Regulations

MC-011 MEDICAL CARE TRUST FUND PROGRAM

MC-011

The fund created by W&IC Section 124.5, technically known as the Medical Care Premium Deposit Fund, as well as the county fund created by W&IC Section 4604.5, technically known as the Medical Care Revolving Fund, into which are deposited:

1. Warrants drawn by the State Controller pursuant to W&IC Section 460 and
2. Transfers made from the assistance appropriation pursuant to W&IC Sections 2020.003 and 3084.05.

MC-012 USE OF COMMUNITY RESOURCES

MC-012

Community resources which are available without charge to all members of the community and services available to the applicant or recipient at no charge through other state or federal programs are to be utilized in preference to payment from the Medical Care Trust Fund.

MC-013 USE OF PREPAID MEDICAL CARE PLANS

MC-013

When all or any portion of a recipient's medical need is covered under any prepaid medical care plan or insurance, need is to be met from such medical care plan to the fullest extent possible before any payment from the Medical Care Fund.

MC-014 PRACTITIONER

MC-014

A person licensed to practice in California by the Boards of Medical Examiners, Dental Examiners, Osteopathic Examiners or Chiropractic Examiners; or

A person licensed to practice in other states by equivalent boards with respect to services provided California recipients within such other states; or

A person who meets the standards for occupational therapists adopted by the Council of Medical Education and Hospitals of the American Medical Association; or

A person authorized to heal by prayer or spiritual means by a bona fide sect, denomination or organization approved by the State Department of Social Welfare.

Optometrists, licensed by the California State Board of Optometry, are recognized practitioners of the healing arts. However, the resources of the Medical Care Trust Fund do not permit, at this time, the inclusion of refractions and/or eyeglasses in the coverage of the fund (see Sec. MC-030, Scope and Limitations). For this reason the optometrist is not now listed among the practitioners defined in this section.

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 (Pursuant to Government Code Section 11380.1)

Regulations

MC-020 WHO ARE ELIGIBLE TO RECEIVE SERVICES

MC-020

Medical and related services and supplies are available under Chapter 1, Part 3, Division 5 of the W&IC to the following:

- Recipients of Old Age Security
- Recipients of Aid to Needy Blind
- Recipients of Aid to Partially Self-supporting Blind Residents
- Children included in the family budget unit under the Aid to Needy Children Program
- Children in Boarding Homes or Institutions receiving Aid to Needy Children
- Needy parents (including incapacitated parents) or needy persons taking the place of parents, living with children receiving Aid to Needy Children
- Recipients of Aid to Needy Disabled

A person who is not receiving aid solely for the reason that aid is withheld to adjust for a previous overpayment is nevertheless entitled to medical care.

A person whose aid is suspended solely for determining the amount of aid he should receive is nevertheless entitled to medical care.

Payment under the Medical Care Trust Fund Program is not available for OAS and AB recipients whose income is sufficient to meet their nonmedical needs and/or nursing home needs, and who consequently have assistance funds up to the statutory maxima available to meet their medical needs.

MC-020.1 ELIGIBILITY OF ATD RECIPIENTS TO RECEIVE SERVICES

MC-020.1

A. ATD recipients eligible for functional improvement services, within the limitations of the Medical Care Fund, are those:

1. Who can benefit from physical restoration or achieve a greater degree of self-care through the receipt of specified services and assistive devices, and
2. Who show evidence of sufficient feasibility and motivation to warrant expenditures, and
3. For whom the required services are not otherwise available or accessible.

B. The provision of functional improvement services shall be limited to:

1. Those who apply for ATD on or after October 1, 1959.
2. Those who meet the requirements under (A) above at time of annual reinvestigation.
3. Those who request functional improvement services or for whom such services are requested.

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Regulations

MC-021 PRIORITY OF RESOURCES

MC-021

The resources of the Medical Care Trust Fund Program shall not be used to pay for medical or remedial service if it has been determined that the recipient is entitled to the use of community resources.

All services included within the scope of the Medical Care Program, as covered by the Medical Care Trust Fund Program, are to be paid by warrants drawn on the Medical Care Revolving Fund.

MC-022 FACILITIES

MC-022

Payment from the Medical Care Trust Fund Program, except as provided in Section MC-031.5, may be made, within the maxima allowed, for services rendered by private practitioners, group practices, public clinics or voluntary clinics, but, insofar as practical, no recipient shall be deprived of free choice of practitioner willing to provide services under the terms of these rules and regulations.

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Regulations

MC-030 SCOPE AND LIMITATIONS

MC-030

For Old Age Security, Aid to the Blind, and Aid to Needy Children
see Sections MC-031.1, MC-031.2, MC-031.3 and MC-031.6.

For Aid to Needy Disabled see section [REDACTED] MC-031.5.

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Regulations

SCOPE AND LIMITATIONS

MC-031.2

MC-031.2 DRUGS FOR OLD AGE SECURITY AND AID TO THE BLIND PAID BY MEDICAL CARE FUND - UNRESTRICTED BY DIAGNOSIS MC-031.2

Acetazolamide
Aminophylline (All USP forms)
Aminopterin Sodium
Atropine Sulfate USP

Belladonna Tincture USP
Bishydroxycoumarin USP
Busulfan

Camphorated Opium Tincture USP
Chiniofon
Chlorambucil
Chlormerodrin
Chlorothiazide
Chlorpropamide
Codeine Phosphate or Sulphate USP
Colchicine USP

Desoxycorticosterone Acetate
Injection USP
Digitalis USP
Digitoxin USP
Dihydrotachysterol
Diphenylhydantoin Sodium USP

Emetine Hydrochloride USP
Ephedrine Sulfate USP
Epinephrine USP

Ferrous Sulfate USP

Glyceryl Trinitrate USP

Hydralazine Hydrochloride

Insulin (all forms)
Isoproterenol Hydrochloride USP

Mechlorethamine HCl NF
Meperidine HCl USP
Meralluride Injection USP
Mercaptopurine

Neostigmine Bromide USP

Oxygen USP

Penicillin-V (Limit #20 Caps. or Tabs.
per Rx)

Pentobarbital Sodium USP

Phenobarbital USP

Physostigmine Salicylate USP

Pilocarpine HCl and Nitrate USP

Posterior Pituitary USP

Primaquine Phosphate USP

Procainamide HCl USP

Procaine Penicillin G. Suspension USP
(Injection)

Quinidine Sulphate USP

Reserpine USP

Sodium Radio-Chromate USP

Sodium Radio-Iodide USP

Sodium Radio-Phosphate USP

Streptomycin USP

Sulfisoxazole USP

Tetanus Antitoxin USP

Tetanus Toxoid USP

Tetracycline (oral) any USP or NND Form
(Limit #16 Caps. or Tabs. per Rx)

Thyroid USP

Tolbutamide

Triethylenethiophosphoramide (ThioTEPA)

Trihexyphenidyl HCl

Trisulfapyrimidines, USP (triple sulfas)

Underlined items are not payable from the Fund if prescribed under any brand name.

Combinations of drugs in a prescription are not payable from the Medical Care Fund.

The presence of therapeutically inert pharmaceutical adjuncts does not constitute a combination.

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MC-031.3 SCOPE AND LIMITATIONS Regulations

MC-031.3 DRUGS PAID FOR OLD AGE SECURITY AND AID TO THE BLIND BY MEDICAL CARE FUND - RESTRICTED BY SPECIFIC DIAGNOSIS MC-031.3

1. Addison's Disease and Disseminated Lupus Erythematosus

Cortisone USP

2. Cancer

Diethylstilbestrol USP

Methyltestosterone USP

Testosterone (all USP forms)

3. Malaria

Chloroquine Phosphate USP

4. Pernicious Anemia and/or Combined Sclerosis

Cyanocobalamin USP (B₁₂) Intramuscular injectable only

Liver Extract USP Intramuscular injectable only

When the drugs listed in this section are prescribed for the specific diagnosis shown, the practitioner shall indicate this by writing "Code 1" on the Form MC-165.

Combinations of drugs in a prescription are not payable from the Medical Care Fund.

The presence of therapeutically inert pharmaceutical adjuncts does not constitute a combination.

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MC-031.5 ATD FUNCTIONAL IMPROVEMENT PROGRAM--SERVICES AND ITEMS AVAILABLE MC-031.5

The purpose of the ATD functional improvement program is to provide a range of remedial services, including medical, psycho-social and other services, needed to assist recipients to achieve the best possible adjustment and maximum functional improvement within the limits of their disabilities. The goal shall be to build upon and supplement existing community services and not to subvert or supplant such services.

Services and items related to a plan for functional improvement shall not exceed \$300 in any 12 months period. Of this amount, the cost of evaluation services shall not exceed \$75.

Expenditures for evaluation services may be authorized in any three months period for a maximum of 5 percent of the ATD caseload of each county or for a minimum of two cases per county.

Only the following services and items considered essential to a plan for functional improvement (including evaluation and/or treatment) may be authorized for payment from the Medical Care Revolving Fund:

1. Physician home or office visits, as indicated (including necessary X-ray and laboratory services), to evaluate functional improvement needs and to provide treatment and continuing direction of physical restoration and self-care services.
2. Nursing services, if the recipient lives outside a geographical area which is being served by visiting nurse services and if the public health department is unable to provide nursing services.
3. Physical and occupational therapy services under medical supervision for functional evaluation and/or treatment.
4. Appliances and assistive devices (excluding dentures, hearing aids and glasses), if not available from other sources in the community.
5. Household rehabilitation equipment, including bathroom rails, parallel bars, modified chairs and toilet seats, pulleys, overbed trapeze bars, bedboards, devices to aid dressing and eating, etc. (See ATD Manual Sec. D-202.20 for items allowable within the grant.)

Expenditures are not authorized from the Medical Care Revolving Fund for any of the above services rendered by a public medical facility or which are otherwise available within the community to ATD recipients.

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Regulations

SCOPE AND LIMITATIONS

MC-033

MC-031.6 SERVICES AVAILABLE TO ALL RECIPIENTS EXCEPT AID TO DISABLED
WITH PRIOR AUTHORIZATION

MC-031.6

(See MC-031.5 for ATD)

- A. Home and/or office visits from or to practitioners (other than dentists and chiropodists) in excess of three such visits for any other illness or beyond the 90th day from the first visit.
- B. Any service rendered by chiropodists.
- C. For Aid to Needy Children recipients only special medical supplies not listed in the schedule of maximum allowances, but required as a part of a specific treatment plan.
- D. Elective laboratory services other than urinalysis and blood counts.
- E. Elective radiological services.
- F. (Item repealed December 1, 1958.)
- G. Services of private nurses or services of visiting nurse associations in excess of five visits for any one illness.
- H. Dental care for children under 13 years of age as necessary to prevent tooth loss.
- I. Complete histories and physical examinations by physicians.
- J. Services of physical therapists as prescribed by physicians.
- K. Services of rehabilitation centers meeting the standards of the Bureau of Vocational Rehabilitation.

MC-033

DURATION OF PRIOR AUTHORIZATION FOR ALL RECIPIENTS EXCEPT AID TO
DISABLED.

MC-033

A prior authorization shall be valid until notice of cancellation is received from the county welfare department.

In case of dental care a period of 10 days from date of cancellation will be allowed for completion of minimum work necessary.

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Regulations

MC-040 SCHEDULE OF MAXIMUM ALLOWANCES

MC-040

The following allowances constitute the maximum payment that may be made for the specified service or procedure. No additional charge to the recipient will be permitted.

No payment will be made for any procedure performed in a hospital for other than outpatient services, such as diagnostic laboratory or X-ray services, physical therapy, or procedures performed on an emergency outpatient basis.

No payment will be made for elective office surgery. Elective, or optional office surgery is any surgical procedure which can be deferred as it is neither life extending nor life saving. Diagnostic surgery requiring biopsy is not considered elective.

No payment will be made for diagnosis or treatment given in the absence of the recipient, e.g., telephone calls.

No payment will be made for the treatment of mental illness or for radium or X-ray therapy.

Under the Aid to Needy Children program payment will be made for the treatment of tuberculosis, venereal disease, and for prenatal care. Payment for these conditions will not be made for recipients under other public assistance programs.

No payment will be made for rehabilitative services at a rehabilitation facility unless the practitioner submits a complete plan for rehabilitation in advance of referral.

This schedule includes most procedures contemplated as necessary and normally performed in any locality on an outpatient basis. However, other procedures may be included if they are determined to be in accordance with local community practice.

No payment may be made for any service or care rendered to patients admitted to and registered in a hospital and in a facility, such as an adjunct nursing home, operated as a part of such hospital.

No payment will be made for services in behalf of recipients of Aid to the Disabled unless the services are included under Section MC-031.5, and are approved in advance by the county.

MC-046 SCHEDULE OF MAXIMUM ALLOWANCES, DRUGS AND MEDICAL SUPPLIES

MC-046

No payment will be made in behalf of Old Age Security and Aid to the Blind recipients for drugs or medical supplies except for those items set forth in Sections MC-031.2 and MC-031.3. (See Sec. MC-031.1.)

No payment will be made in behalf of Aid to Needy Disabled recipients for drugs or medical supplies.

(Continued)

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Regulations

MC-046 (Continued)

MC-046

The maximum allowances for drugs and medical supplies shall not exceed the lesser of the usual retail selling price or the following amounts:

1. Drugs which may not be dispensed by the druggist under federal or state laws except upon prescription by a physician, dentist or chiropodist:
 - a. The wholesale price of the drug may be increased by an amount not to exceed 50 percent, plus
 - b. A single prescription fee of \$1.15 is allowed for each prescription.
2. Drugs which may be dispensed by the druggist under federal or state laws without a prescription:
 - a. Fair trade items - the maximum payment to be made is the fair trade price.
 - b. Items not classified as fair trade - The wholesale price may be increased by an amount not to exceed 50 percent.
3. Medical Supplies:
 - a. Fair trade items - The maximum payment to be made is the fair trade price.
 - b. Items not classified as fair trade - The maximum is regular retail price less 10 percent.

The pharmacist shall dispense the lowest cost item he has in stock meeting the requirements of the practitioner as shown on the prescription form. Substitutions of name brand items will not be made.

All prescriptions for narcotics shall be accompanied by the required federal prescription form.

Prescriptions must be filled within seven days from the date of issue and are not refillable.

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MC-040.4 SCHEDULE OF MAXIMUM ALLOWANCES Regulations
MC-040.4 (Continued) MC-040.4

Pro. No.	Procedure	Maximum Charge	Pro. No.	Procedure	Maximum Charge
PATHOLOGY (Continued)			MISCELLANEOUS (Continued)		
TISSUES (Continued)			8956	Basal metabolic rate	\$4.80
8911	culture for bacteria screening	\$4.00	8957	Electrocardiogram, with interpretation and report	10.00
8912	culture for bacteria, definitive	8.00	8958	without interpretation and report	4.00
8917	Cytologic study (Papanicolaou smear)	10.00	8959	interpretation and report only (tracing not done by interpreting physician)	6.00
8918	gastric or pepsin	18.00	8960	exercise test, with interpretation and report	14.00
URINE			8967	Urinary 17-ketosteroids	10.00
8930	Routine chemical, qualitative	.80	8968	11-oxysteroids	12.00
8931	Quantitative sugar	1.20	8969	gonadotropins	12.00
8932	Routine microscopic	.80	8970	Residual air determination	By report
8933	Bence-Jones protein	.80	8971	Bronchspirometry (See 2126.)	20.00
8934	Complete routine (chemical and microscopic)	1.60	8972	Exclusion test for pheochromocytoma (Regitine, etc.)	6.00
8935	Quantitative functional (Addis)	4.00	8973	Direct smear without stain	1.00
8936	Concentration and dilution tests	1.60	8974	Miscellaneous smear for bacteria with stain	2.40
8937	Sugar fermentation	.30	8976	Miscellaneous culture for bacteria screening	4.00
8938	Phenosulfenphthalein	4.00	8978	Miscellaneous animal inoculation for bacteria	10.00
8939	Porphyrins, qualitative	4.00	8979	Miscellaneous culture for bacteria definitive	8.00
8940	quantitative	10.00	8983	Vital capacity	2.40
8941	Smear for bacteria	2.40	8984	Muscle appraisal, complete (galvanic)	15.00
8942	Porphobilinogen	2.40	8987	Skin tests with bacterial extracts (each) (Brucella, Frei, Tuberculin, etc.)	3.20
8943	Culture for bacteria screening	4.00	8988	Venous pressure	4.00
8944	Lead, quantitative	12.00	8989	Circulation time	4.00
8945	Culture for bacteria, definitive	8.00	8991	Stone analysis, qualitative	4.00
8946	Quantitative calcium (Sulkowitch)	1.20	8992	quantitative	12.00
8947	Bile pigments	1.20	8994	Transudates and exudates, microscopic (See 8903)	
8948	Quantitative chemical examination (see Blood)		8995	Culture screening	4.00
8949	24-hour calcium	4.00	8996	definitive	8.00
MISCELLANEOUS			8997	Animal inoculation	10.00
8950	Electroencephalogram	20.00	8998	Chemical (see Blood)	
8951	Antibiotic sensitivity, per antibiotic (pyrogenic)	1.60	8999	Ventilation studies, complete (respirometer), including spiogram, timed vital capacity, maximal breathing capacity, with interpretation and report	12.00
8953	Autogenous vaccine	12.00			
8954	Audiometer testing, any method	6.00			
8955	Barany vestibular test	8.00			

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Regulations

MC-049	OCCUPATIONAL THERAPY - ATD ONLY	MC-049
1.	Case consultation in Rehabilitation Center This is provided in conjunction with physician and other professional services.	\$5.00
2.	Case consultation away from office or Rehabilitation Center This is provided in conjunction with or under the supervision of a physician.	7.50
3.	Single treatment visit (less than $1\frac{1}{2}$ hours)	4.50
4.	Rehabilitation Center therapy (more than $1\frac{1}{2}$ hours to half day)	6.00
5.	Rehabilitation Center therapy (more than $3\frac{1}{2}$ hours to full day)	9.00
MC-049.5	PROSTHETISTS AND ORTHOTISTS - ATD ONLY	MC-049.5
	Consultation	\$7.50

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Regulations

MC-051 RECIPIENTS

MC-051

Whenever a recipient requests medical or related care from a vendor he shall exhibit the identification card issued him under Sec. MC-023, Identification Card.

Medical care statements and prescriptions payable from the Medical Care Trust Fund Program shall be signed by the recipient or his representative.

Vendors shall submit statements of services rendered by the 10th day of the month following each month of service. Statements received later than 6 months after the last day of the month in which the service is rendered shall not be paid.

With respect to services for which the department has executed an agreement with a fiscal agent, vendors shall submit statements of services rendered to such fiscal agent. Each statement shall carry the vendor's certification that the charges within the maximum allowed under Chapter MC-04, constitute the only charges made for the services rendered.

MC-053 COUNTIES (AND FISCAL AGENTS INSOFAR AS APPLICABLE)

MC-053

Each county shall have available to it a full- or part-time medical consultant (M.D. or D.O.) who, under the direction of the county welfare director, shall authorize, or recommend authorization of, the services listed in Section MC-031.2.

For the authorization of complete dental care to children the county shall avail itself of dental consultation.

Counties in whose behalf the SDSW has executed an agreement with a fiscal agent shall supply the fiscal agent with such information as the SDSW finds necessary for the fiscal agent to render the services specified in the agreement.

Statements received from vendors shall be audited to determine:

- A. That recipient was eligible at time of service
- B. That statement was fully completed
- C. That authorization, if necessary, was obtained
- D. That charges for service are within the maxima permitted under Chapter MC-04.

Payment for medical or remedial services or supplies shall be made within 30 days from the date of receipt of statement.

Payments to vendors shall be accompanied by a copy of the vendor's statement or a transmittal form which identifies the patient(s), the amounts paid on behalf of each patient and the month in which service was rendered.

(Continued)

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Regulations

MC-053

MC-053 (Continued)

The county shall maintain a system of records which enables it to easily determine the total cost of medical care rendered a particular recipient and which makes available to the caseworker such information as is necessary for casework services. The county shall use forms specified by SDSW or substitute form or procedure approved by SDSW.

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Regulations

MC-053.70 AUTHORIZATION OF SERVICES UNDER FUNCTIONAL IMPROVEMENT PROGRAM MC-053.70

County authorization of services provided by Section MC-031.5 shall be based upon a decision by the SDSW that the case is potentially feasible for functional improvement services. The county, through its Medical Consultant and other appropriate staff, shall direct such evaluation and treatment services as are authorized by the SDSW.

MC-054 PROCEDURAL REQUIREMENTS - ATD FUNCTIONAL IMPROVEMENT CASES MC-054

The identification of recipients who are potentially feasible for functional improvement services shall be made on all cases as follows:

- (a) New cases at the time aid is granted
- (b) Continuing cases
 - 1) At the time of annual renewal if case has not been previously considered
 - 2) At the time previously specified for reconsideration for feasibility
- (c) When consideration for such services is requested by a recipient.

Evaluation and Treatment (For scope see Section MC-031.5)

For cases identified by the SDSW as potentially feasible for functional improvement services, the county should, within 60 days following the granting of aid, the date of reaffirmation or the request for services:

- (a) Secure the necessary evaluation work-up and, when indicated,
- (b) Develop a suitable treatment plan.

All cases shall be processed to a point of decision. For cases identified as feasible for functional improvement services, the county shall prepare a statement which includes:

- (a) Summary of evaluation findings
- (b) Description of proposed plan for functional improvement services
- (c) Estimate of duration of Plan
- (d) Estimate of cost
- (e) Date plan is to be re-evaluated.

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MC-054 Continued

MC-054

Functional improvement plans shall be re-evaluated as often as necessary but not less frequently than once every three months. All plans shall be re-evaluated at termination of authorized treatment. Plans no longer valid in relation to factors listed in MC-020.1(A) or for other appropriate reasons shall be discontinued.

The county shall maintain a system of records which enables the county and the SDSW to review and evaluate the results of the ATD Functional Improvement Program. The county shall use the forms and evaluation methods prescribed by the SDSW.

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The following number change is to be effective 10-1-59:

MC-031.5 it to be changed to MC-031.6

The following section is to be repealed effective 10-1-59:

MC-013 Income Resources

DO NOT WRITE IN THIS SPACE